Please print and use only black ink

Thank you, from the staff of Curley Chiropractic

Curley Chiropractic

Teenager's Health History Form

Personal Data

Date:______________

Full Name____ **Age:** __________ **DOB:** ______________

Parent's names: ____

Home Address: ____ **City:** _________________________
State_______ **Zip**___________ **Social Security #:**__________________________

Language: [ ]English [ ]Spanish [ ]Indian [ ]Japanese [ ]Chinese [ ]Korean [ ]French [ ]German
[ ]Russian Other:_____________________

Race/Ethnicity: [ ] White [ ]American Indian or Alaska Native [ ] Asian [ ]Native Hawaiian/ other pacific Islander [ ]Black or African American [ ] Hispanic or Latino [ ]Decline Answer Other:________________

Cell Phone: ___________________________ **Cell Provider:** ___________________________________

E-mail _______________________________ **Emergency contact:** _______________________________

Whom may we thank for referring you to our office? ____

Insurance Information: *A copy of your insurance cards will be made, in addition, please complete the information requested below*

Who is the policy holder? __________________________________ Policy holders DOB: _____________

Policy holders Social Security: _______________________ Policy holders employer: ________________

Do you have secondary insurance? Y N If yes, please complete the following:

Policy holders Name: ____ DOB: ______________

Policy holders Social Security: ___________________ Policy Holders employer: ___________________

REASON FOR SEEKING CHIROPRACTIC CARE

How do you think we may help be able to you're your teenager? ________________________________

____

Are these concerns affecting your child's activities of daily living? (Circle Y to those that apply)

Eating:	Y N	Sleep:	Y N	Running:	Y N
School:	Y N	Walking:	Y N	Sitting:	Y N
Exercise/sports:	Y N	Relationships:	Y N	Other: _____________	

PREVIOUS CHIROPRACTIC CARE

Has your teenager ever received Chiropractic care? Y N Name of D.C.__________________

How long were they under care? _____________________ Date of last visit: __________________

FOR THE TEENAGER

Tell us about you.

Are you an athlete? Y N If yes which sport(s).___________________________________

Have you played this sport or have you ever played a sport? For how long? _______________________

Do you remember ever getting hurt playing this sport? Y N If yes, tell us when and describe the injury.____

TELL US MORE

Are you in the school band? Y N If yes what instrument do you play? _________________________

Have you had any accidents or injuries in your life related to any of the following? (Check all that apply)

___Automobile ___Motorcycle ___Bicycle ___Playground

If you have checked any of the above please state the type of injury and date: _____________________

____

Have you ever hurt, broken, fractured or sprained any bones or joints? Y N

If yes, list body parts injured and dates if not already listed above:_______________________________

____

Have you ever been hospitalized? Y N

If yes, tell us the dates and reasons if not already listed above:__________________________________

FOR PARENTS

The following questions pertain to <u>at any point in the patient's life did any of these occur</u>.
As a baby or toddler, did any of the following occur to your teenager?

___ fall from a changing table	___ frequent crying spells	___ frequent fevers
___ tumble from stair	___ fall out of crib	___frequent diarrhea
___involved in car accident	___constipation	___sleeping problems
___play in jumper	___frequent colds	___colic
___tonsillitis	___ fall off playground equipment	___ did not gain weight
___reaction to vaccination	___ other	

Explain any of the above if needed____

____

Has your teenager ever had any vaccinations?____

Did your teenager ever have any reactions to any vaccinations? _______________________________

Has your teenager experienced any of the following?

___headaches	___numbness in arm/hands	___foot/ankle/knee pain
___dizziness	___arm/wrist pains	___tingling in arms/legs
___ringing in ears	___sleeping problems	___neck/back pain
___asthma	___allergies	___shoulder pains
___hyperactivity	___stomach problems	___growing pains
___fatigue	___weight gain or loss	___other______________

Which of the above that you checked would you consider the worst? ____________________________

____

Do any of the following still occur? ____

If yes, list which ones____

Is this condition: ___constant ___intermittent ___occasional ___cyclic

QUALITY OF LIFE

When this condition is at its worst, how does it make your child feel? _____________________________

____

Is there anything you have done for your child regarding this condition that has NOT worked? ________

____

Describe any hospital or emergency room stays? ____

____

Approximately how many times have antibiotics been prescribed for your child and for what conditions?

____

List any medications your child is currently taking: ____

____

Is there anything else you think we should know about your child?________________________________

____

EXPECTATIONS

I would like to have the following benefits for my teenager from Chiropractic Care: (check all that apply)

_____Relief of a symptom or problem

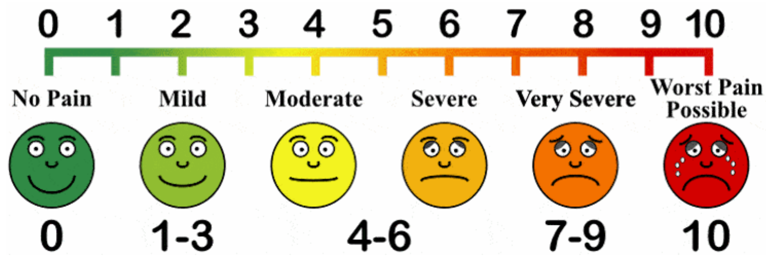
_____Relief and prevention of a symptom or problem

_____Healthier spine and nerve system

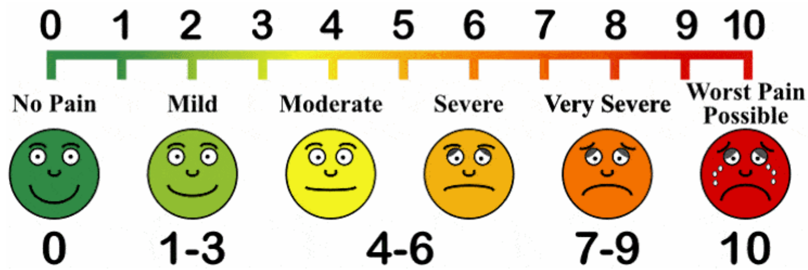
_____Optimal Health on all levels

Circle the number at where your pain is at:

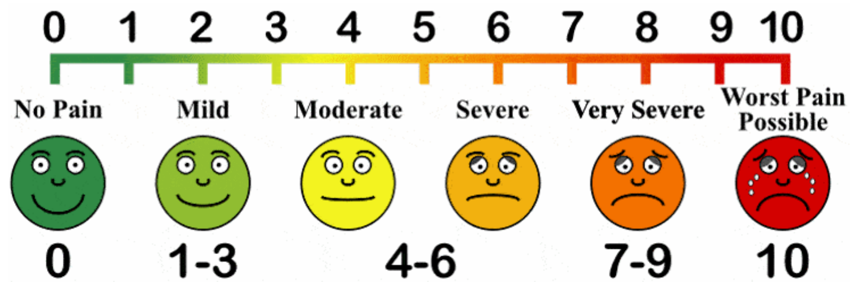
Neck



Shoulders and Mid upper back



Lower Back and Hips/Legs



YOUR INFORMED CONSENT

The information I have provided on this case history form, is true and accurate to the best of my knowledge. Although Chiropractic is reported to be the safest health care system in the world, some say there are very slight risks associated with it. We feel that it is responsible to let you know: 1. While extremely rare, there have been reports of ligament sprains, and even rib fractures reported; 2. There have been rare reports of disc injuries although no clinical scientific study has ever demonstrated chiropractic care to be the cause. Chiropractic care has been proven to be both, clinically and cost effective. The risk of injuries and complications is so small that chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world. Compared to traditional medical/drug/surgical care, which has a yearly death rate of approximately 200,000 people in North America, Chiropractic is your safest health care system.

I have read and understand the above consent and have had the opportunity to discuss it with my chiropractor. I have been informed and fully understand that Chiropractic care is not a treatment of any disease or condition. I consent to the care recommended by my chiropractor and extend this consent to include all doctors of Curley Chiropractic. This consent applies to all present and future care for me and my family

Signature____Date_________________

Signature of Parent (for minor)____Date_______________