SEAHURST

Chiropractic and Wellness Clinic

ADOLESCENT INFORMATION FORM (13-17 YRS)

Patient Information

Name:_____ Date: _____
Date of birth:_____ Age: _____
Parent/Guardian's name(s): _____
Street address: _____
City:_____ State:_____ Zip code: _____
Home phone:_____ Cell phone: _____
Email address: _____
Insurance Provider/ID#: _____
Whom may we thank for referring you? _____

Patient History

How would you describe the pregnancy? ☐ Normal ☐ Somewhat difficult ☐ Very difficult
How would you describe infancy? ☐ Normal ☐ Somewhat difficult ☐ Very difficult
How would you describe childhood? ☐ Normal ☐ Somewhat difficult ☐ Very difficult
If you answered anything but normal, why? _____
_____
How would you describe overall physical development?
❑ Above average ☐ Typical ☐ Behind schedule
How would you describe overall mental development?
❑ Above average ☐ Typical ☐ Behind schedule
Any childhood illnesses/diseases? _____
Any surgeries? _____
Any accidents? _____
Has your child been immunized? Yes/No
If yes, which ones? _____
Reason: ☐ Informed decision ☐ Recommended ☐ Didn't know I had a choice
Did your child have any negative reaction to the vaccines? Yes/No
If yes, were they reported? Yes/No
Has your child been on antibiotics? Yes/No
If yes, how often and what purpose? _____
Is your child currently taking any medication? Yes/No
If yes, how often and what purpose? _____
Is your child currently taking any vitamins? Yes/No
If yes, how often and what purpose? _____
Is there anything significant in patient's health history the Doctor should know?
_____

(See Reverse)

Health & Wellness

What is the reason for your visit today? ☐ Wellness Check---Up ☐ Other
Other: _____
If other, how long has this been a concern? _____
Is it getting worse? ☐ Yes ☐ No ☐ Not sure
Does it affect activity? ☐ Not at all ☐ Somewhat ☐ Always
Has anything been done already to address this concern? _____

Are any of the following symptoms present?

Stomach pains	Allergies	Repeated colds
Hyperactivity/Autism	Growing Pains	Digestion
Leg/Knee pains	Headaches/Migraines	General fatigue
Scoliosis	Seizures	Acne/Skin problems
Learning difficulties	Infections	Depression
Low energy Asthma	Tonsillitis	Menstrual cramps
Irritability/Moodiness	Diarrhea	Anxiety
Low self---esteem	Constipation	Excessive hunger
	Sleeping problems	

Other _____

Do you participate in any athletic extra curricular activities? Yes/No
If yes, which ones? _____
Rate your diet: ☐ Well---balanced ☐ Average ☐ High sugar/processed foods
Do you consume artificial sweeteners? Yes/No
Rate your exercise: ☐ Frequently ☐ Sometimes ☐ Never
How many glasses of water do you drink?_____/day
Number of hours you sleep?_____hours/day
Sleep quality? ☐ Good ☐ Fair ☐ Poor
Rate your general mood: ☐ Happy ☐ Melancholy ☐ Depends on the day
Is there anything else you would like the Doctor to know? _____

Authorization to treat a Minor

I,_____the undersigning parent/guardian having legal custody/guardianship of_____, a minor, do herby authorize, request, and direct the staff and doctors of Seahurst Chiropractic to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Patient's name: _____
Parent/Guardian's signature: _____ Date: _____