Name: _____

Date: _____

AHC #: _____

Email Address: _____

Under Canada's new anti-spam legislation, we are required to ask you for your consent to contact you via email for appointment reminders and information regarding your health. Do you consent? _____ (YES) _____(NO) _____

Sign or Initial here

Adolescent Health Record

Ages 10-17

Relax • Breathe • Smile ☺

We are happy you are here!

As a full spectrum Wellness Centre, we focus on your child's ability to be healthy. Our goals are firstly, to address the issues which brought your child into our office, and secondly to offer your child the opportunity of improved health potential as he or she continues to grow and develop. On a daily basis, children experience physical, chemical and emotional stress which can accumulate and result in a loss of health and compromised function. If these stressors are not addressed, they may affect your child's development well into adulthood. Answering the following questions will provide us with a profile of the specific stressors your child faces, allowing us to better assess the challenges to your child's health.

BEACON HILL
CHIROPRACTIC AND MASSAGE
~NORTHWEST~

About Your Child

Child's Name: _____Age: _____ Birthdate M/D/Y:_____ □ M □ F

Height:_____ Weight: _____ Name of MD: _____ Date of last checkup: _____

Parent's Name: _____

Address: _____City:_____ Prov: _____ PC: _____

Phone (h): _____ Phone (c): _____Phone (w): _____

# of Children in family: _____ Parents: □ Married □ Single □ Divorced □ Separated □ Widowed

Parent's Employer: _____

Alternate Person to Contact In Case of Emergency:

Name: _____ Phone Number: _____(h) _____(c)

Please check to receive the following via e-mail:

□ **Appointment Reminders** □ **Patient Newsletters** **Email Address** _____

Reason For This Visit

Describe the purpose of this visit: _____

Is this visit related to: □ School □ Sports □ Auto Accident □ Fall □ Chronic Discomfort □ Injury □ Other

Please explain: _____

Date of Onset? _____/_____/_____ Onset was □ Sudden □ Gradual □ Associated with an Event

Has this condition: □ gotten worse □ gotten better □ stayed the same □ comes and goes

Does this condition interfere with: □ work/school □ sleep □ daily routine □ athletic activities □ play □ social functioning

Explain: _____

What activities make this condition better?_____

What activities make this condition worse?_____

Effects of condition on body function and daily activities: _____

Have you seen anyone else for this condition? □ Y □ N

Doctor or Clinician's Name:_____

Type of Treatment: _____Medications given:_____

Result: _____

Vaccinations

Have you chosen to vaccinate your child? ☐ Y ☐ N

If "yes", check all vaccinations your child has received:

☐ DPT ☐ Hepatitis ☐ MMR ☐ German Measles ☐ Other

☐ Polio ☐ Gardasil ☐ Chicken Pox ☐ Flu Shot ______________

Describe any reactions (either immediate or delayed) to vaccinations: ______________

____

Family Health History

☐ Diabetes ☐ Depression ☐ MS ☐ Heart Disease ☐ Osteoporosis ☐ Stroke ☐ High Blood Pressure

☐ Arthritis ☐ Cancer ☐ Adverse Vaccine Reactions ☐ Digestive Issues/Irritable Bowel

☐ ____

Goals For My Child's Care

Children see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your child's needs and goals when recommending a treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care – Symptomatic relief of pain or discomfort

☐ Corrective Care – Corrective and relieving the cause of the problem a

☐ Comprehensive Care – Bring whatever is malfunctioning in the body c care

☐ I want the Doctor to select the type of care appropriate for my child's

____

Patient Signature

Other Concerns

If you have any other concerns regarding your child's health, please list here:

____

____

. . . experienced impacts/falls/jolts? ☐ No ☐ Yes

. . . had stitches or fractures? ☐ No ☐ Yes

Explain ______________________

. . . been hospitalized? ☐ No ☐ Yes

Explain ______________________

____

. . . had a severe fall? ☐ No ☐ Yes

. . . been in a car accident? ☐ No ☐ Yes

. . . had a severe illness? ☐ No ☐ Yes

Explain ______________________

____

. . . had a surgery? ☐ No ☐ Yes

For what? ______________________

____

. . . had a foot or gait problems? ☐ No ☐ Yes

Was your child's birth traumatic? ☐ Prolonged labor

☐ Drug induced ☐ Forceps ☐ C-Section

☐ Premature ☐ Cord around neck ☐ Natural

Has your child experienced any of the following:

☐ Nightmares ☐ Insomnia ☐ Bedwetting

☐ Teeth grinding

Has your child taken antibiotics? ☐ No ☐ Yes

If "yes", explain ______________________

Is your child currently taking any medication? ☐ No ☐ Yes

If "yes", explain ______________________

Does your child have difficulty interacting with schoolmates or friends? ☐ No ☐ Yes

Does your child's social and emotional development seem normal for his/her age? ☐ No ☐ Yes

Explain: ______________________

What changes (if any) in your child's health or behavior would you like accomplished ______________________

____

Experience with Chiropractic

Who referred you to our office?

____

Have your child ever been adjusted by a Chiropractor? ☐ Y ☐ N

Reason for visits? ______________________

How long ago? ______________________

Doctor's Name? ______________________

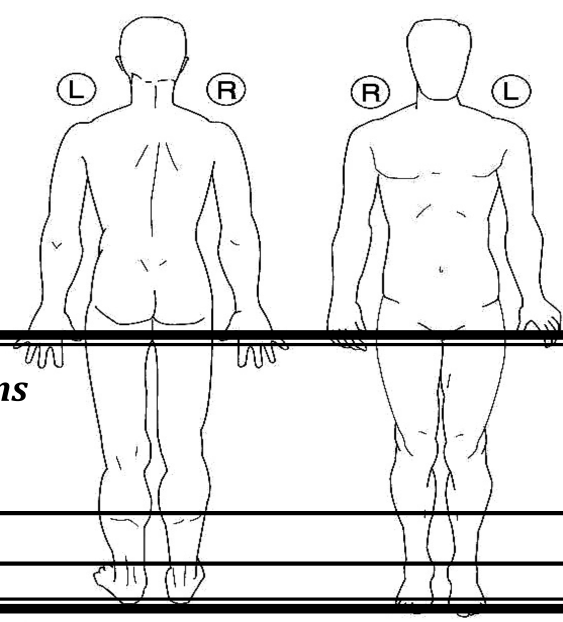
Date of last visit? ______________________

Has any **adult** in your family seen a Chiropractor? ☐ Y ☐ N

Has any **child** in your family seen a Chiropractor? ☐ Y ☐ N

Were you aware that:

- Doctors of Chiropractic work with the nervous system? ☐ Y ☐ N
- The nervous system controls all bodily functions and systems? ☐ Y ☐ N
- Chiropractic is the largest natural healthcare profession in the world? ☐ Y ☐ N
- If Chiropractic care starts at birth, you can achieve a higher level of health throughout your whole life? ☐ Y ☐ N



DRAW YOUR PAIN

Using a pen - mark in the areas on the diagrams where you have pain/numbness.

X = Pain
o = Numbness