FAMILY WELLNESS CENTRE
DR. JON DIPLOCK, CHIROPRACTOR

ADOLESCENT HEALTH RECORDS

Date: _____

PERSONAL HEALTH HISTORY

Name: _____ Birth Date: _____/_____/_____ Age: _____ Gender ☐ M ☐ F
Parents/Guardians Name: _____
Address _____ City: _____ Province_____ Postal Code: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Physician's Name: _____ Referred to our office by: _____

NATURE OF VISIT

☐ Wellness Check-up
☐Symptoms/Complaint_____
_____
Other Doctors seen for this condition: ☐ No ☐ Yes, if yes then who? _____
Type of treatment: _____ Results: _____
When did this condition begin? _____ Has this condition occurred before? ☐ Yes ☐No
What aggravates the child's condition? _____
What relieves the child's condition? _____
Is it getting: ☐ Better ☐ Worse ☐ No change ☐ Comes and goes ☐ Constant
Please list any medications the child is currently taking: _____
_____

PRENATAL HISTORY

Who did the mother see for prenatal care: ☐ Midwife ☐ Obstetrician ☐ Other: _____
Were there any problems during pregnancy? ☐ No ☐ Yes: _____

BIRTH HISTORY

Who did the mother see for prenatal care? ☐ Midwife ☐Obstetrician ☐ Other:_____
Were there any problems during the pregnancy?☐No ☐C-Section ☐Yes:_____
Delivery Method: ☐ Vaginal ☐ Planned C-section ☐ Emergency C-section
Was the birth assisted? ☐ No ☐ Yes: ◯ Induction ◯ Forceps ◯ Vacuum extraction

SLEEPING HABITS & POSITIONS

What position does the baby sleep? ☐ Back ☐ Side ☐ Stomach
Are there any sleeping problems? ☐ No ☐ Yes: _____
How many hours does the baby sleep during the night? _____

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FAMILY HISTORY

Are there any conditions or diseases that run in your family: _____
Is there asthma or allergies in the family? ☐ No ☐ Yes
Are there pets in the home? ☐ Yes ☐ No
Are there smokers in the home? ☐Yes ☐No

Has your child experienced any of the following?
☐ Accidents/Falls_____ Treatment? _____
☐ Asthma _____ Treatment? _____
☐ Colds _____ Treatment? _____
☐ Constipation _____ Treatment? _____
☐ Diarrhea _____ Treatment? _____
☐ Ear Infections _____ Treatment? _____
☐ Fevers _____ Treatment? _____
☐ Flu _____ Treatment? _____
☐ Headaches _____ Treatment? _____
☐ Leg/Growing Pains_____ Treatment? _____
☐ Surgery_____ Treatment? _____
☐ Other _____

LIFESTYLE

Nutrition

How is the child's overall nutrition: ☐ Poor ☐Good ☐ Excellent
How often does the child consume the following:

FRUITS:	☐Always	☐ Couple times per week	☐ Never
VEGETABLES:	☐Always	☐ Couple times per week	☐ Never
JUNK FOODS:	☐Always	☐ Couple times per week	☐ Never
POP/JUICES:	☐Always	☐ Couple times per week	☐ Never
VITAMINS:	☐Always	☐ Couple times per week	☐ Never
CIGARETTES/VAPE:	☐Always	☐ Couple times per week	☐ Never

Do you have any nutritional concerns for the child? ☐ No ☐ Yes:_____

Exercise

How often does the child exercise? ☐ Daily ☐ Couple of times per week ☐ Infrequently
Does the child participate in any organized sports? ☐ No ☐ Yes:_____

Stress

Overall how is the child's level of stress? ☐ Low ☐ High: ◯ School ◯ Work ◯ Home

Health

How would you rate the child's overall health on the following scale (please circle)?

0 1 2 3 4 5 6 7 8 9 10
Least Healthy Moderate Health Most Healthy

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