Northwest Family
CHIROPRACTIC & MASSAGE

YOUNG ADULT INFORMATION FORM (13-17 YRS)

Patient Information

Name: ____ Date: ________________

Date of birth: ______________ Age: _______ Sex: Male Female

Parent/Guardian's name(s):____

Current Health Concern

What is the primary reason that you are seeking Chiropractic care for your child?

____

When did it begin? ____

How did it begin? Suddenly Gradually Following an accident

Is it getting worse? Yes No

What makes it better? ____

What makes it worse? ____

Have you ever experienced a similar condition? Yes No

Please explain: ____

Have you been card for by another provider for this complain? Yes No

Please explain: ____

Does it affect your daily activity? Not at all Somewhat Always

Which activities are affected? ____

Child Health History

Place of birth: Home Birthing Center Hospital

Provider: Midwife OB-Gyn Other

Type of birth: Vaginal Cesareans

List any food/environmental allergies: ____

Does your child have regular bowel movements? Yes No

Current weight: _____________________________ Current height: ___________________________

List any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime.

Include the year: ____

____

List any major hospitalizations or surgeries your child has experienced. Include the year: ____________

____

Has your child ever been checked for vertebral subluxations? Yes No I don't know

Are there 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	Tonsillitis	Menstrual cramps
Asthma	Diarrhea	Anxiety

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Irritability/Moodiness Constipation Excessive hunger
Low self-esteem Sleeping problems
Other: ____

Chemical Stressors

Has your child been vaccinated? Yes No
Reason: Informed decision Recommended Did not 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, please list: ____
How many glasses does your child drink per day? Water ______ Milk ______ Juice _____ Soda _____
Does your child consume artificial sweeteners? Yes No
Rate your child's diet: Well-balanced Average High sugar/ processed foods
What is your favorite food?____

Is there anything else the Doctor should know? ____
____
Have you, the child's legal guardian, had any personal experience with Chiropractic? Yes No

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Authorization to evaluate and care for 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 Northwest Family Chiropractic & Massage to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Patient's name: ____
Parent/ Guardian's signature: ____ Date: __________________

Our Mission is to provide a profound health care experience in a professional and genuine environment. We empower our clients through individualized Chiropractic programs and lifestyle coaching and inspire our clients to uncover the natural healing power from within.

Welcome to NW Family Chiropractic & Massage