Mar 2024

ADOLESCENT CHIROPRACTIC - INTAKE FORM

BEACON HILL
CHIROPRACTIC AND MASSAGE

Adolescent's (10-17)

Full Name: _____ ***M / F / Other*** **Date:** _____

Date of Birth (M/D/Y): _____ **Age:** _____ **Occupation:** _____

Address: _____ **City:** _____ **Prov:** _____ **Postal Code:** _____

Cell phone: _____ **Home phone:** _____ **AHC:** _____

Patient's phone number: _____ **Occupation:** _____

Parent/Guardian Name(s): _____ **Phone Number:** _____

Do you consent to emails regarding appointment reminders and clinic/health information? _____ **Yes** _____ **No**

Email: _____ **Initials:** _____

How were you referred to Beacon Hill Chiropractic & Massage?

◯ Online ◯ Website ◯ Walk by ◯ Lives in area ◯ Other: _____ ◯ Current patient: _____

Experience with Chiropractic

Have you ever been adjusted by a Chiropractor before? ◯ Yes ◯ No How long ago? _____

Doctor's name? _____ Reason for visit? _____

REASON FOR THIS VISIT

Is this visit due to or in any way related to: ◯ School ◯ Sports ◯ Injury ◯ Fall ◯ Car accident ◯ Other: _____

If motor vehicle related, will this visit be part of a MVA claim? Y / N

Please describe the reason for your visit: _____

When did this condition begin? _____ Has it gotten: ◯ Worse ◯ Better ◯ Stayed the same ◯ Comes/goes

Does this condition interfere with: ◯ Sleeping ◯ Eating ◯ Daily routine ◯ Movement

Explain: _____

What makes it better? _____ Worse? _____

Have you seen anyone else for this condition? Doctor/clinician's name: _____

Type of treatment: _____ Result: _____

CURRENT HEALTH STATUS

Have you ever been hospitalized? ◯ Yes ◯ No Explain: _____

Had a severe fall? ◯ Yes ◯ No Explain: _____

Been in a car accident? ◯ Yes ◯ No Explain: _____

Has a severe illness? ◯ Yes ◯ No Explain: _____

Had a surgery? ◯ Yes ◯ No Explain: _____

Taken antibiotics? ◯ Yes ◯ No Explain: _____

Do you have gastrointestinal issues? ◯ Yes ◯ No Explain: _____

Do you have pets in the home? ◯ Yes ◯ No Explain: _____

Does anyone in the home smoke? ◯ Yes ◯ No Explain: _____

Do you play sports? ◯ Yes ◯ No Which sports? _____ How many hours a week? _____

How heavy is your backpack? ◯ Very heavy ◯ Heavy ◯ Moderately heavy ◯ Not heavy

Do you have difficulty interacting with schoolmates or friends? ◯ Yes ◯ No

Do you engage in activities which require prolonged awkward positions or repetitive postures? (ie: violin, gymnastics)

◯ Yes ◯ No Explain: _____

FULL NAME: _____

Please **CHECK** any current/past conditions

CARDIOVASCULAR
- ◯ Blood clots
- ◯ Blood pressure: HIGH
- ◯ Blood pressure: LOW
- ◯ Congenital heart defect
- ◯ Heart murmur
- ◯ Heart surgery
- ◯ Hemophilia
- ◯ Poor circulation

RESPIRATORY
- ◯ Asthma
- ◯ Lung infections
- ◯ Pneumonia

GASTROINTESTINAL
- ◯ Constipation
- ◯ Crohn's or Colitis
- ◯ Digestive problems
- ◯ Gallbladder/Jaundice
- ◯ IBS or IBD
- ◯ Nausea/Vomiting

SKIN CONDITIONS
- ◯ List any:

_____

MUSCLE/BONE/JOINT/DISC
- ◯ Ankle swelling
- ◯ Arthritis
- ◯ Back pain
- ◯ Bursitis
- ◯ Fractures/Breaks:

  _____
- ◯ Inflammation
- ◯ Plates/Pins
- ◯ Scoliosis
- ◯ Pain b/w shoulder blades
- ◯ Sprain/Strain
- ◯ Trauma/Falls
- ◯ Weakness/Instability

NEUROLOGICAL
- ◯ Brain injury
- ◯ Cerebral palsy
- ◯ Epilepsy
- ◯ Fainting
- ◯ Migraines
- ◯ Loss of motor control
- ◯ Meningitis
- ◯ Nerve damage: _____
- ◯ Numbness in arms/legs/ hands/feet/_____
- ◯ Seizures

HEAD & NECK
- ◯ Dizziness
- ◯ Ear infection
- ◯ Headache
- ◯ Hearing loss
- ◯ Neck pain
- ◯ Difficulty with swallowing
- ◯ Ringing in ears (tinnitus)
- ◯ Sinus problems
- ◯ Sleep loss/problems
- ◯ TMJ disorder
- ◯ Vertigo
- ◯ Vision problems
- ◯ Whiplash

MENTAL HEALTH
- ◯ Alcohol/drug abuse
- ◯ Anxiety
- ◯ Bipolar disorder
- ◯ Depression
- ◯ Eating disorder
- ◯ Panic attacks
- ◯ Stress

DIAGNOSED CONDITIONS
- ◯ ADD/ADHD
- ◯ Autoimmune disease
- ◯ Cancer:

  _____

  (radiation/chemotherapy)
- ◯ Diabetes (I / II)
- ◯ Infectious disease:

  _____
- ◯ Urinary system issues
- ◯ Other:_____

FEMALES ONLY
- ◯ Cramps/back pain
- ◯ Irregular cycles
- ◯ Painful menstruation
- ◯ Other:

  _____

ALLERGIES

Allergic to:

_____

Reaction:

_____

EpiPen? YES / NO

Please list any other conditions that are relevant to your health:

_____

FAMILY HEALTH HISTORY

◯ Arthritis ◯ Depression ◯ Digestive issues/IBS ◯ High blood pressure ◯ Osteoporosis
◯ Cancer ◯ Diabetes ◯ Heart disease ◯ Multiple sclerosis ◯ Stroke

MEDICATIONS/SUPPLEMENTS

Some drugs can cause neuro-musculoskeletal symptoms. It is important for our chiropractors to know what medications you are currently taking. Symptoms you present in clinic may be related to these medications. If you are unsure of your medications it is <u>imperative</u> that you let us know at your next visit.

◯ Acid reducers ◯ Birth control ◯ Blood thinners ◯ Muscle relaxers ◯ Stimulants
◯ Antidepressants ◯ Blood pressure meds ◯ Insulin ◯ Pain killers (NSAIDS/Ibuprofen)

Medications	Dosage	Duration	Reason
Nutritional supplements	Dosage	Duration	Reason

FULL NAME: _____

HEALTH & LIFESTYLE

	YES	NO	Frequency
Smoking			/day
Alcohol			/day
Coffee			/day
Cannabis			/day
CBD Oil			/day

Please note that treatment will be withheld for any patient under the influence of alcohol or non-prescription drugs

Current height: _____
Current weight: _____

How frequently do you consume/participate in the following per day?						
	0	1-2	3-4	5-6	7-9	10+
Glasses of water						
Fruits/vegetables						
Sugary treats						
Salty treats						

How frequently do you participate in the following per week?					
	0x	1x	2-3x	4-5x	6+
Cardio exercise					
Strength training					

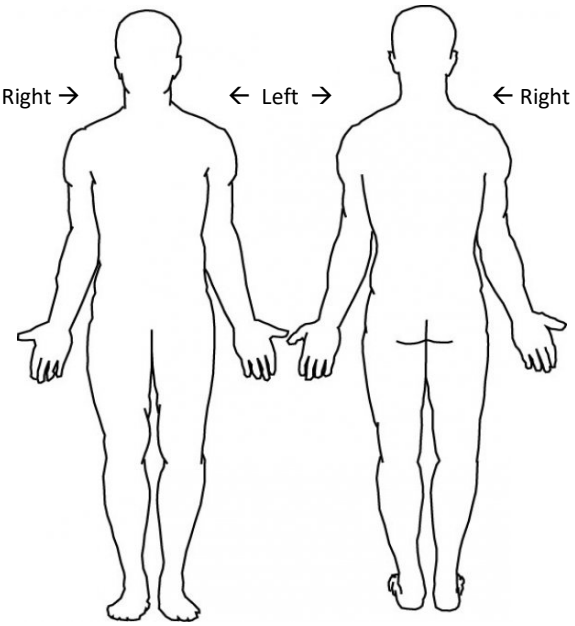
HABITS

How is your sleep? _____ How many hours a night do you sleep? _____
Describe your energy: _____
What are your hobbies? _____
Do you wear foot support/orthotics? ◯ Yes ◯ No

PAIN/DISCOMFORT DIAGRAM:

Please mark these diagrams according to where you feel pain. Please also indicate which sensations you feel by referring to the key below:

KEY
///// **Stabbing**
XXXX **Aching**
**Burning**
>>>> **Pins/Needles**
0000 **Numbness**



PLEASE CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

0-3 – No pain; Mild pain **4-7** – Moderate pain; medication required **8-10** – Severe pain; daily life impacted

What changes in your health or behavior would you like to accomplish? _____
_____
_____
_____
_____