Westernport Innate Chiropractic

TEEN CONFIDENTIAL PATIENT INFORMATION

Full name:			
Parents names:			
Address: Street	Suburb	State	P/Code
Home phone:	**Mobile:**		
Email address:			
Date of birth:	**Age:**		

Whom may we thank for referring you? _____

*If you have no symptoms or complaints and are here for Chiropractic Wellbeing Services, please skip to the **"General Health History"**.*

Health Concerns- What can we help you with today?

Please list your health concerns/symptoms according to their severity	Rate of severity 1 =mild 10 =terrible	When did this episode start?	Have you had this condition before, if so, when?
1.			
2.			

Have you seen anyone else for this condition? _____ If so, whom? _____

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐

What aggravates your condition? _____

Is this condition interfering with any of the following:

School/Work ☐	Sleep ☐	Daily Routine ☐	Sports/Exercise ☐	Other ☐(please explain):

Please mark any of the following conditions you may have had:

☐ Allergies	☐ Arthritis	☐ Asthma	☐ Convulsions	☐ Depression	☐ Eczema
☐ Ear Infections	☐ Learning Difficulties	☐Headaches/ Migraines	☐ ADD/ADHD	☐ Frequent Colds/Flu	☐ Sporting injuries/ Broken Bones

Other (please explain) _____

General Health History *Often accumulation of life's stress can lead to health problems and influence your ability to heal. Please pay close attention to this, as it will help us help you!*

Have you had any surgery?

1. Type:	When?
2. Type:	When?

Have you had any accidents and/or injuries: car, sport-related, or other? (Especially those related to your present problems).

Type:	When?	Hospitalised? Yes □	No □
Type:	When?	Hospitalised? Yes □	No □

Current Medicines and Supplements

Please list any medications/drugs, nutritional supplements, vitamins, or homeopathics you have taken regularly in the past 6 months and why: (prescription and non-prescription)

_____

_____

Diet Please indicate which of these are part of your regular diet:

Coffee	Energy drinks eg. Red Bull	Refined Sugar	Junk Food
Soft Drinks	Alcohol/Tobacco	Weight Control Diet	Protein Supplements

Stressors Because problems that we see are often caused or exacerbated by an accumulation of stress, it is important that we get an idea of the stress levels in your life.

Please rate your present levels of stress using High, Medium or Low:

At school/work:	At home:	At play:

Using Good, Average or Poor please rate your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:

Has your problem/s forced you to give anything up or modify your life in any way? If so, what/how? _____

_____

Is there anything else which hasn't been covered which you feel is important for the doctor to know? If so, what? _____

_____

_____

I, the undersigned, being the parent/guardian of _____, certify that the above information is correct. I hereby consent to the performance of a complete chiropractic examination and treatment by any registered chiropractor engaged by Westernport Innate Chiropractic. I have been informed of all the risks associated with the recommended treatment in terms that I have understood and have also been given the opportunity to ask questions. I understand that results are not guaranteed and that the chiropractor will always act in the patient's best interests based on the facts known at that time. I acknowledge, being the parent/guardian that any fee for services rendered are due at the time of the service and cannot be deferred to a later date. I understand the above and consent to chiropractic treatment for the patient's present condition and any future condition(s). I also understand that I can withdraw my consent at any time.

Print Parent Name: _____

Signature: _____ Date: _____