Complete Family Chiropractic & Wellness Centre – Dr. Guillet, Dr. Hewitt

Date

428 Westmount Avenue, Unit 1A Sudbury, Ontario P3A 5V8 (705) 525-1221

Patient No.

Adolescent Health History(12-17 years)

PERSONAL HEALTH HISTORY

DD/MM/YYYY

Name: _____ Birthdate: _____ Age: _____ Gender: ☐M ☐FParents/Guardians

Name:_____

Address: _____City:_____

Province: _____ Postal Code: _____ Home Phone: _____

Parent's Work Phone: _____ Parent's Cell Phone: _____

Physician's Name: _____ Extended Health Coverage: ☐ Yes ☐ No ☐ Not sure

Email address: _____ Siblings: _____

Referred To This Office By: _____

NATURE OF THIS VISIT

☐ Wellness Checkup

☐ Symptoms/Complaint:

_____

_____

Other doctors seen for this condition: ☐No ☐Yes: Who? _____

Type of Treatment: _____Results_____

When did this condition begin? _____ Has this condition occurred before? ☐No ☐Yes, _____

What aggravates the child's condition?_____

What relieves the child's condition? _____

Is it getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better

Previous Accidents/Falls: _____

List any medications the child is currently taking: _____

_____

Expectations for Treatment: _____

_____

Previous Chiropractic treatment: ☐ None ☐ Chiropractor's name and date of last visit:_____

PRENATAL& BIRTH HISTORY

Who did the mother see for prenatal care? ☐Midwife ☐Obstetrician ☐Other: _____

Were there any problems during the pregnancy? ☐No ☐Yes, _____

_____

Delivery Method: ☐Vaginal ☐Planned C-Section ☐Emergency C-Section

Was the birth assisted: ☐No ☐Yes, How? ☐Induction ☐ Epidural ☐Forceps ☐Vacuum extraction

SLEEPING PATTERNS & POSITIONS

Sleeping position? ☐Back ☐Side ☐Front/Stomach

Are there any sleeping problems? ☐No ☐Yes: _____

How many hours of sleep during the night? _____

FAMILY HEALTH HISTORY

Are there any conditions/diseases that run in your family? ☐No ☐Yes, _____

_____

Is there asthma or allergies in the family? ☐No ☐ Yes ☐Whom? _____

Are there any pets in the home? ☐No ☐Yes, _____

Are there any smokers in the home? ☐No ☐Yes, _____

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SYSTEMS

Please check the appropriate box for any of the following symptoms which the child now has (currently) or has had previously.

P = Previously **C** = Currently

P C
☐☐ Pneumonia
☐☐ Mumps
☐☐ Measles
☐☐ Influenza
☐☐ Rheumatic Fever
☐☐ Whooping Cough
☐☐ Polio
☐☐ Chicken Pox
☐☐ Pleurisy
☐☐ Arthritis
☐☐ Tuberculosis
☐☐ Diabetes
☐☐ Epilepsy
☐☐ HIV
☐☐ Cancer
☐☐ Mental Illness
☐☐ Anemia
☐☐ Heart Disease
☐☐ Bleeding Disorder
☐☐ Hemophilia
☐☐ Thyroid
☐☐ Eczema
☐☐ Colitis

Musculo-Skeletal

☐☐ Low Back Pain
☐☐ Pain Between Shoulders
☐☐ Neck Pain
☐☐ Arm Pain
☐☐ Shoulder Pain
☐☐ Leg Pain
☐☐ "Growing pains"
☐☐ Knee Pain
☐☐ Joint Pain/Stiffness
☐☐ Walking Problems
☐☐Difficulty Chewing/Clicking Jaw
☐☐ General Stiffness

Nervous System

☐☐ Nervous
☐☐ Numbness
☐☐ Paralysis
☐☐ Dizziness
☐☐ Forgetfulness/Confusion
☐☐ Depression
☐☐ Fainting
☐☐ Convulsions
☐☐ Cold/Tingling Hands/Feet
☐☐ Always feel cold
☐☐ Always feel warm

Cardiovascular
P C
☐☐ Chest Pain
☐☐ Shortness of Breath
☐☐ Asthma
☐☐ Blood Pressure Problems
☐☐ Heart Problems
☐☐ Lung Problems/Congestion

General

☐☐ Fatigue
☐☐ Allergies
☐☐ Loss of Sleep
☐☐ Loss of weight
☐☐ Fever
☐☐ Headaches

Ear, Nose & Throat

☐☐ Deafness
☐☐ Earache
☐☐ Ear infections
☐☐ Ear ringing/buzzing
☐☐ Vision Problems
☐☐ Eye Pain
☐☐ Nose Bleed
☐☐ Sinus Infection
☐☐ Sore Throat
☐☐ Enlarged thyroid
☐☐ Tonsillitis

Digestive

☐☐ Gas/Bloating After Meals
☐☐ Excessive Thirst
☐☐ Frequent Nausea
☐☐ Vomiting
☐☐ Black/Bloody Stool
☐☐ Diarrhea
☐☐ Constipation
☐☐ Weight Trouble
☐☐ Abdominal Cramps
☐☐ Heart Burn/Indigestion

Female

☐☐ Menstrual Cramping
☐☐ Menstrual Irregularity
☐☐ Vaginal Pain/Infections
☐☐ Breast Pain/Lumps

Urinary
P C
☐☐ Bladder Trouble
☐☐ Bed-wetting

Intake
☐Juice #cups/day:_____
☐ Coffee #cups/day:_____
☐ Tea #cups/day: _____
☐ Alcohol Amount/day:_____
☐ Cigarettes Amount/day:_____
Years smoking:_____
☐ Soft Drinks Amount/day:_____
☐ Vitamins (incl brand): _____
_____
_____

Personal satisfaction with diet

1 2 3 4 5
I----------I----------I----------I----------I
Satisfied Neutral Dissatisfied

Does the child have a regular exercise program?

☐ No ☐Yes: _____
_____
_____
Any organized sports? _____
_____
_____

Lifestyle Stress Levels
☐ High
☐ Moderate
☐ Low

Is the child vaccinated?
☐ No ☐Yes: _____
_____
_____
Any Reactions?: _____
_____

Has the child received any vaccines in the last year?
☐ No ☐Yes: _____
_____
Any Reactions?: _____
_____