# ADOLESCENT CHIROPRACTIC - INTAKE FORM

MY Life HEALTH CENTER
Chiropractic - Weight Loss - Massage

## *Adolescent's (10-17)*

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

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

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

**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 M.Y. Life Health Center?**

◯ Online ◯ Website ◯ Walk by ◯ Lives in area ◯ Other: _____ ◯ Person: _____

◯ 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

Please 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 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
- ◯ Pneumonia
- ◯ Lung infections

**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 imperative that you let us know at your next visit.*

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

| **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*

| *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 | | | | | |

Describe your sleep habits: _____

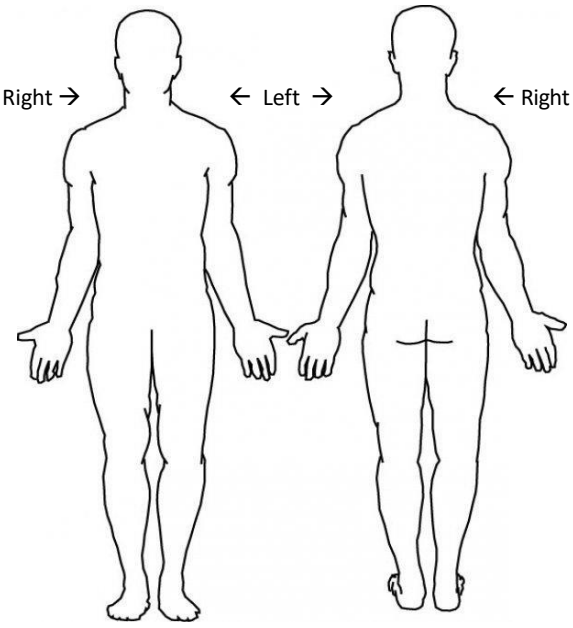
How would you describe your energy? _____

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 would you like to accomplish?** _____

_____

_____

_____

_____

FULL NAME: _____

I understand that I am directly and fully responsible to M.Y. Life Health Center LLC for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

**CONSENT TO CHIROPRACTIC CARE**

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

I,_____, being the parent or legal guardian of_____hereby grant permission for my child to receive chiropractic care at M.Y. Life Health Center

Signed_____ Date: _____

Relationship to Child: _____

Witnessed_____ Date _____

Doctor Signature:_____ Date _____

M.Y. LIFE HEALTH CENTER
Chiropractic - Nutrition Testing - Massage

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