13 + years

Teen Confidential Patient Information

Child Name: _____ D.O.B: _____/_____/_____ Gender: M☐ F☐

Parent/Guardian Name(s): _____

Siblings (names and age): _____

Address: _____

Phone: _____ Email: _____

Paediatrician/Dr: _____

Do you have private health cover: Yes / No. If so, which fund? _____

How did you hear about Tamar Chiropractic? _____

Reason for today's visit *(if coming in for a check-up, please leave the following 6 questions blank):*

_____

_____

_____

When did this condition begin? _____

Have there been any change(s) in condition since onset? _____

_____

What makes the condition better? _____

What makes the condition worse? _____

Have there been previous episodes? _____

If other health practitioners have been consulted, please provide details: _____

_____

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

_____

Please list any previous medications: _____

Please list medical illnesses/diagnoses: _____

Have you ever been hospitalised? _____ Have you ever had surgery? _____

Have you had any significant falls/accidents/trauma? _____

Please circle whether you have suffered from any of the following symptoms, whether past or present:

Headache	Sinus troubles	Scoliosis	Constipation
Migraine	Tonsillitis	Reflux	Diarrhoea
Ear ache/infections	Asthma/chronic cough	Frequent colds & flu's	Digestive disorders
Hip problems	Preferred head position	Motion sickness	Poor sleeping habits
Developmental delay	Poor coordination	Colic	Allergies

Other:

_____

_____

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? _____
_____

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

Tick any of the following that you have had or do have:

☐ ADD / ADHD / ASD	☐ Anxiety	☐ Depression	☐ Learning Difficulties

Other (please explain) _____

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

Coffee	Energy Drinks	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:*

_____

Please rate accordingly using *Good, Average or Poor:*

Eating habits: *Exercise habits:* *Sleep:* *General health:* *Mindset:*

_____

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?
_____
_____

CANCELLATION POLICY

Tamar Chiropractic & Allied Health is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us by 5pm the business day prior to your scheduled appointment to notify us of any changes. Failure to do so incurs a fee equal to that of the booked appointment.

Print Parent Name: _____

Signature: _____ Date:_____