



Adolescent Intake Form

Child's Name _____ Preferred Name _____

Parent's (Guardian's) Name _____ Mom Dad Step-mom Step-dad

Address _____
City _____ State _____ Zip _____

Home Phone _____ Parent's Cell Phone _____

Parent's Email address: _____ Adolescent's email: _____

SS# _____ Birth Date _____ Age _____

School your child attends: _____ Grade or Level: _____

Check all that apply: Drink Coffee _____ Drink Sweet Tea _____ Milk _____
(Specify Amounts) Artificial Sweeteners _____ Juice/Sports Drinks _____
 Soft Drinks _____ Candy _____

Please List:

Please list all meds. OTC & Prescribed

Medications	For What Condition	Taken How Long
1. _____	_____	_____
2. _____	_____	_____

Vitamins/Supplements/Herbs	For What Condition	Taken How Long
1. _____	_____	_____
2. _____	_____	_____

Has your child recently been vaccinated? yes no If yes, for what? _____

Has your child ever had any reaction to vaccinations? yes no not sure

If YES or NOT SURE please Explain: _____

How would you best describe their diet? poor fair adequate good excellent

How many servings of *different* fruits/vegetable do they eat per day? _____

Activity Level: Please check those that best describes your child:

- My child is extremely involved in competitive sports. * Please specify sport/activity _____
- My child is moderately active. He/she plays some sports or dances and enjoys outdoor activities almost daily.
- My child is occasionally active. He/she may do things like ride their bike, swim, or toss the ball a few times/week.
- My child is seldom active. The only activity he/she may get is in P.E. class.
- My child does not participate in P.E. class on a regular basis.

Learning Ability:

- My child does very well at school.
- My child struggles with some subjects but overall enjoys learning.
- My child has had difficulty getting their homework done and usually falls behind in their work.

Has your child ever seen a Chiropractor before? yes no If yes, who?

Chiropractor _____ City _____ Last seen? _____

For what? _____

List medical doctor(s) you have seen within the past year:

1. Name _____ City _____ Last seen? _____
Reason for visit _____

2. Name _____ City _____ Last seen? _____
Reason for visit _____

List ALL Surgeries/Hospitalization/Broken bones/ Stitches/ Accidents/ Sprains/Strains:

Type _____ Date _____

Type _____ Date _____

Type _____ Date _____

REASON FOR TODAY'S VISIT: _____
HOW LONG HAS IT BEEN A PROBLEM: _____ Days Weeks Months Years
What makes it better? _____
What makes it worse? _____

Health History

Below are a list of symptoms. Please check if your child has had or is currently suffering from any of the following:

Past	Symptom	Present	Past	Symptom	Present
<input type="radio"/>	neck pain	<input type="radio"/>	<input type="radio"/>	low back pain	<input type="radio"/>
<input type="radio"/>	headaches	<input type="radio"/>	<input type="radio"/>	migraines	<input type="radio"/>
<input type="radio"/>	arm/hand tingling	<input type="radio"/>	<input type="radio"/>	shoulder pain	<input type="radio"/>
<input type="radio"/>	leg pain	<input type="radio"/>	<input type="radio"/>	jaw pain	<input type="radio"/>
<input type="radio"/>	chest pain	<input type="radio"/>	<input type="radio"/>	hives / itchy skin	<input type="radio"/>
<input type="radio"/>	heart problems	<input type="radio"/>	<input type="radio"/>	concussion	<input type="radio"/>
<input type="radio"/>	swelling in ankles	<input type="radio"/>	<input type="radio"/>	cold extremities	<input type="radio"/>
<input type="radio"/>	blurred vision	<input type="radio"/>	<input type="radio"/>	sinus infections	<input type="radio"/>
<input type="radio"/>	allergies	<input type="radio"/>	<input type="radio"/>	fainting	<input type="radio"/>
<input type="radio"/>	unexplained weight loss	<input type="radio"/>	<input type="radio"/>	poor appetite	<input type="radio"/>
<input type="radio"/>	excessive appetite	<input type="radio"/>	<input type="radio"/>	nervousness	<input type="radio"/>
<input type="radio"/>	socially withdrawn	<input type="radio"/>	<input type="radio"/>	depression	<input type="radio"/>
<input type="radio"/>	dental problems	<input type="radio"/>	<input type="radio"/>	excessive thirst	<input type="radio"/>
<input type="radio"/>	nausea	<input type="radio"/>	<input type="radio"/>	irregular menstrual cycle	<input type="radio"/>
<input type="radio"/>	acne	<input type="radio"/>	<input type="radio"/>	breast pain/lumps	<input type="radio"/>
<input type="radio"/>	cramps	<input type="radio"/>	<input type="radio"/>	painful urination	<input type="radio"/>
<input type="radio"/>	bladder troubles	<input type="radio"/>	<input type="radio"/>	discolored urine	<input type="radio"/>
<input type="radio"/>	gas/bloating	<input type="radio"/>	<input type="radio"/>	heartburn	<input type="radio"/>
<input type="radio"/>	anorexia/bulimia	<input type="radio"/>	<input type="radio"/>	bloody stools	<input type="radio"/>
<input type="radio"/>	constipation	<input type="radio"/>	<input type="radio"/>	hemorrhoids	<input type="radio"/>
<input type="radio"/>	asthma	<input type="radio"/>	<input type="radio"/>	learning challenges	<input type="radio"/>
<input type="radio"/>	fatigue	<input type="radio"/>	<input type="radio"/>	loss of sleep	<input type="radio"/>
<input type="radio"/>	difficulty hearing	<input type="radio"/>	<input type="radio"/>	ear infections	<input type="radio"/>
<input type="radio"/>	mid back pain	<input type="radio"/>	<input type="radio"/>	Other _____	<input type="radio"/>

OUR COMMITMENT TO YOU!

As our commitment to your wellness and EXTRAordinary service to you, we would be honored to submit a written copy of your findings to your primary care physician and/or other health care professional. We will also provide a copy to you. Please simply supply us with your other doctors' names and city of practice and we will do the rest.
