KehoeFamily Chiropractic
7212 Massachusetts Ave
New Port Richey, FL 34653
www.kehoechiro.com
727-859-9700

*Caring for families in sickness and in health.*

# 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 _____

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.

**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:**
**Type** _____ **Date** _____

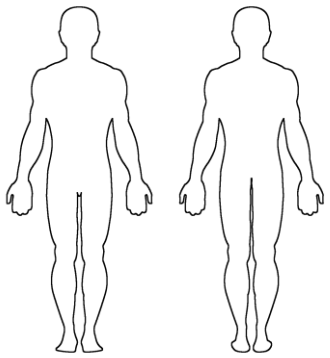
**Past Accidents/Injuries/Stitches/Broken Bones**
**Type** _____ **Date** _____

**Type** _____ **Date** _____

**CURRENT CONDITION**

**REASON FOR YOUR VISIT TODAY:** _____
***If this visit is for general wellness/spinal maintenance please skip to next section.**
**HOW LONG HAS IT BOTHERED YOU? ❍Days ❍Weeks ❍Months ❍Years**
**Have you seen anyone else for this so far? ❍ Yes ❍ No**
**If Yes, who? Name and type of practitioner.** _____
**What have you done so far for this situation?** _____
**What makes your situation better?** _____
**What makes your situation worse?** _____

**On a scale of 1-10 (1= least pain 10= most pain)**
**How would you rate your situation?** _____
**Please specify on the diagram, the location of your pain or discomfort.**



**FRONT BACK**

## Health History

**Below are a list of symptoms. Please check if you have had, or are currently suffering from any of the following:**

| Past | Symptom | Present |
|---|---|---|
| ❍ | neck pain | ❍ |
| ❍ | headache | ❍ |
| ❍ | arm/hand tingling | ❍ |
| ❍ | leg pain | ❍ |
| ❍ | chest pain | ❍ |
| ❍ | heart problems | ❍ |
| ❍ | swelling in ankles | ❍ |
| ❍ | blurred vision | ❍ |
| ❍ | allergies | ❍ |
| ❍ | unexplained weight loss | ❍ |
| ❍ | excessive appetite | ❍ |
| ❍ | confusion | ❍ |
| ❍ | dental problems | ❍ |
| ❍ | nausea | ❍ |
| ❍ | prostate problems | ❍ |
| ❍ | menstrual cramps/irregularity | ❍ |
| ❍ | bladder troubles | ❍ |
| ❍ | gas/bloating | ❍ |
| ❍ | irritable bowel | ❍ |
| ❍ | constipation | ❍ |
| ❍ | liver problems | ❍ |
| ❍ | stroke | ❍ |
| ❍ | fatigue | ❍ |
| ❍ | difficulty hearing | ❍ |
| ❍ | mid back pain | ❍ |
| ❍ | cancer | ❍ |
| ❍ | hip pain | ❍ |

| Past | Symptom | Present |
|---|---|---|
| ❍ | low back pain | ❍ |
| ❍ | migraines | ❍ |
| ❍ | shoulder pain | ❍ |
| ❍ | jaw pain | ❍ |
| ❍ | breathing difficulties | ❍ |
| ❍ | abnormal blood pressure | ❍ |
| ❍ | cold extremities | ❍ |
| ❍ | stuffy nose/sinuses | ❍ |
| ❍ | fainting | ❍ |
| ❍ | poor appetite | ❍ |
| ❍ | nervousness | ❍ |
| ❍ | depression | ❍ |
| ❍ | excessive thirst | ❍ |
| ❍ | vomiting | ❍ |
| ❍ | breast pain/lumps | ❍ |
| ❍ | painful urination | ❍ |
| ❍ | discolored urine | ❍ |
| ❍ | heartburn | ❍ |
| ❍ | bloody stools | ❍ |
| ❍ | hemorrhoids | ❍ |
| ❍ | leg/foot numbness | ❍ |
| ❍ | paralysis | ❍ |
| ❍ | loss of sleep | ❍ |
| ❍ | ear pain | ❍ |
| ❍ | alcohol/substance abuse | ❍ |
| ❍ | leg cramps | ❍ |
| ❍ | Other _____ | ❍ |