Erindale Chiropractic Adolescent Case History

Patient name ____Date_______________________

Address__________________________ City_____________ Postal Code ___________________

Date of Birth _____________ Health Card Number ________________________ Sex: M / F

Mother's Name ____________________________ Phone Number ________________________

Father's Name _______________________________ Phone Number _______________________

Previous chiropractic care? YES / NO with whom? _____________________________

Name of family doctor/Pediatrician: ____

Has your child suffered from any of the following?

- ○ Measles
- ○ Mumps
- ○ Epilepsy/Seizures
- ○ Whooping cough
- ○ Pneumonia
- ○ Polio
- ○ Croup
- ○ Rheumatic Fever
- ○ Meningitis
- ○ Chicken Pox
- ○ Eczema
- ○ Neck Pain
- ○ Ear infection
- ○ Headaches
- ○ Migraines
- ○ Recurrent Colds/Flu
- ○ Mid-back pain
- ○ Hyperactivity
- ○ "Growing Pains"
- ○ Constipation/Diarrhea
- ○ Bed Wetting
- ○ Allergies
- ○ Leg/Foot pain
- ○ Stomach Aches
- ○ Arm/Hand pain
- ○ Asthma
- ○ Recurrent Fever

Drugs taken currently or have taken in the last year:

____

____

Have X-rays been taken in the last year? YES / NO

When? _______________________ Where? ____

Main reason for your visit:

____

____

____

____

How did it start? ____
____

Has this happened before? If yes, when?
____
____

Is it: ☐Getting worse ☐Staying the same

What makes it worse? ____

What makes it better? ____

Have you seen health practitioners for these concerns? Please state what type of health practitioner(s) and the treatment(s) prescribed:

____
____
____
____

Is your child allergic to any medicines or other substances? If so, please indicate:
____
____

Has your child ever had any kind of surgery or been hospitalized? If so, please indicate when and for what reason:
____
____
____
____

Does your child participate in any sports or activities?
____
____

Menstruation: YES / NO Age: _____________

Is there any information, not included on this form, which you would like to discuss? Please explain.
____
____
____
____

Family History of Disease/Illness:

	Diabetes	Cancer	Other:
Father	☐	☐	
Mother	☐	☐	

Siblings ☐ ☐ ________________________

Children ☐ ☐ ________________________