

## Adolescent Application (13 to 17 years old)

Today's Date: \_\_\_/\_\_\_/\_\_\_

Patient's First Name: \_\_\_\_\_ LastName \_\_\_\_\_ M.I. \_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
 Parent's/Guardian's Names: \_\_\_\_\_ Relation To Child: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ Email: \_\_\_\_\_

Have you ever been checked by a Doctor of Chiropractic?  Yes  No  
 If yes, who? \_\_\_\_\_ Were X-Rays taken?  Yes  No

### History

- Do you have any food or other allergies? List: \_\_\_\_\_
- Have you been immunized according to the recommended schedule?  Yes  No
- Reason for vaccination:  Informed decision  Didn't know I had a choice  Recommended
- Did you have any negative reactions to vaccinations?  Yes  No, Were they reported?  Yes  No
- Have you ever had any surgeries?  Yes  No, Please explain: \_\_\_\_\_
- Have you ever been on antibiotics?  Yes  No, How many rounds? \_\_\_\_\_ Reasons: \_\_\_\_\_
- Are you currently taking any meds?  Yes  No Type: \_\_\_\_\_
- Number of rounds of *other* prescription medications you have taken: \_\_\_\_\_ Reason: \_\_\_\_\_
- Are you currently taking any vitamins?  Yes  No Type: \_\_\_\_\_

### Have/Did any of the following ever occur?

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Fall from a tree            | <input type="checkbox"/> Car Accident    | <input type="checkbox"/> Allergies / Asthma    | <input type="checkbox"/> Leg/Knee pain |
| <input type="checkbox"/> Fall off a bicycle          | <input type="checkbox"/> Sports Accident | <input type="checkbox"/> Hyperactivity/Autism  | <input type="checkbox"/> Bed Wetting   |
| <input type="checkbox"/> Fall off of playground unit | <input type="checkbox"/> Scoliosis       | <input type="checkbox"/> Learning difficulties | <input type="checkbox"/> Stomach pains |
| <input type="checkbox"/> Other: _____                | Explain: _____                           |  |  |

### Please check any of the following conditions you have had in the past or present

Past	Present	Past	Present	Past	Present	Past	Present				
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss/Gain
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis General	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Knee/ Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Incoordination	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Visual Change	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol /Drug Dependence	<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	Other Health Problems: _____								

- Which of the above bothers you the most? \_\_\_\_\_ Is it getting worse?  Yes  No
- When did it begin? \_\_\_\_\_ How often does the pain/issue occur?  Constant  Comes and goes
- How much does the complaint affect daily activities/routines?  None  Somewhat  Frequent  Always

## **Lifestyle**

Please check any sports that you play:

- |                                     |                                     |                                     |                                    |  |
|-------------------------------------|-------------------------------------|-------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Soccer     | <input type="checkbox"/> Football   | <input type="checkbox"/> Gymnastics | <input type="checkbox"/> Karate    | <input type="checkbox"/> Hockey            |
| <input type="checkbox"/> Lacrosse   | <input type="checkbox"/> Basketball | <input type="checkbox"/> Dance      | <input type="checkbox"/> Wrestling | <input type="checkbox"/> Baseball/Softball |
| <input type="checkbox"/> Volleyball | <input type="checkbox"/> Swimming   | <input type="checkbox"/> Tennis     | <input type="checkbox"/> Rugby     | <input type="checkbox"/> Other: _____      |

- How would you rate your diet?  Well balanced  Average  High amounts of sugar & processed food
- Do you consume: Artificial sweeteners?  Yes  No or Fluoridated water?  Yes  No
- Number of hours you sleep? \_\_\_\_/day(nap) and \_\_\_\_/night

Is there anything else we should know about you? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **Authorization to Treat a Minor**

I, \_\_\_\_\_, am the undersigning parent/person having legal custody/guardianship whomever s/he may designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment, which is deemed necessary.

Any specific written authorization you provide may be revoked at any time by writing to us as the address provided at the end of this notice.

Name of Patient: (please print) \_\_\_\_\_ Date of birth \_\_\_\_\_

Name of Parent/Guardian: (please print) \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Today's Date \_\_\_\_\_

## **Insurance Information**

Insurer's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation To Child: \_\_\_\_\_

Insurance Card (to be photocopied below):