FAMILY FIRST CHIROPRACTIC & WELLNESS

TEENAGER'S HEALTH HISTORY FORM

PERSONAL DATA

Today's Date___________________________

Name____ Age __________ Date of Birth _______________________

Parent's names____

Home Address_________________________________ City ___________________ State______ Zip ______________

Home phone (____) _________________________ Business Phone (____) ___________________________________

Cell Phone (____) _____________________E-mail address____

Parent's occupation ____

Business Address_______________________________ City____________________State______ Zip ______________

SS# (opt'l)______________________________ Emergency contact ____

Names and ages of teenager's siblings if he/she has any____

Whom may we thank for referring you to our office? ____

REASON FOR SEEKING CHIROPRACTIC CARE

How do you think we may help be able to help you or your teenager? ____

____

Are these concerns affecting you or your teenager's activities of daily living? (Circle Y to those that apply)

Eating:	Y	N	Sleep:	Y	N	Running:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Relationships:	Y	N	Other: ______________________________		

PREVIOUS CHIROPRACTIC CARE

Have you or your teenager ever received Chiropractic care? ❑Y ❑ N Name of D.C. ____________________

How long under care? ❑ ______days ❑______weeks ❑______ months ❑ _______ years

Date of last visit: _______________

FOR THE TEENAGER

Tell us about YOU.

Are you an athlete? ❑Y ❑ N If yes, what sport(s)____

Have you played this sport or have you ever played a sport? For how long? ________________________________

Do you remember ever getting hurt playing this sport? ❑Y ❑ N If yes, tell us when and describe the injury.

____

____

TELL US MORE

Are you in the school band? ❑Y ❑ N If yes, what instrument do you play? ________________________________

Have you had any accidents or injuries in your life related to any of the following? (Check all that apply.)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Playground

If you have check any of the above, please state the ***type of injury and date:***

____

____

Have you ever hurt, broken, fractured or sprained any bones or joints? ❑ Y ❑ N

If yes, list body parts injured and dates if not already listed above***:***____

____

Have you ever been hospitalized? ❑ Y ❑ N

If yes, tell us the dates and reasons if not alreay listed above***:***_____________________________________

FOR PARENTS

The following questions pertain to *at any point in the patient's life* did any of these occur.

As a baby or toddler, did any of the following occur to your teenager?

___ fall from a changing table
___ frequent crying spells
___ frequent fevers
___ tumble from stair
___ fall out of crib
___ frequent bouts of diarrhea
___ involved in car accident
___ constipation
___ sleeping problems
___ play in jumper
___ frequent colds
___ colic
___ tonsillitis
___ fall off playground equipment
___ did not gain weight
___ reaction to vaccination
___ other ____

Explain any of the above if needed: ____

____

Has your teenager ever had any vaccinations? ____

Did your teenager ever have any reactions to any vaccinations? ____

Has your teenager ever experienced any of the following?

___ headaches
___ numbness in arm/hands
___ foot/ankle/knee pains
___ dizziness
___ arm/wrist pains
___ tingling in arms/legs
___ ringing in ears
___ sleeping problems
___ neck/back pain
___ asthma
___ allergies
___ shoulder pains
___ hyperactivity
___ stomach problems
___ growing pains
___ fatigue
___ weight gain or loss
___ other _______________

Which of the above that you checked would you consider the worst?____

____

Do any of the following still occur? ____

If yes, list which ones. ____

Is this condition: ___ constant ___ intermittent ___occasional ___cyclic

QUALITY OF LIFE

When this condition is at its worst, how does it make your teenager feel? ________________________________

____

Is there anything you have done for your teenager regarding this condition that has NOT worked? _______________

____

Describe any hospital or emergency room stays? ____

____

Approximately how many times have antibiotics been prescribed for your teenager and for what conditions?

____

List any medications your teenager is currently taking: ____

____

Is there anything else you think we should know about your teenager?____________________________________

____

EXPECTATIONS

I would like to have the following benefits for my teenager from ***Chiropractic Care***: (Check all that apply)

- ❒ Relief of a symptom or problem
- ❒ Relief and prevention of a symptom or problem
- ❒ Healthier spine and nerve system
- ❒ Optimal health on all levels

YOUR INFORMED CONSENT

The information I have provided on this case history form, is true and accurate to the best of my knowledge. Although Chiropractic is reported to be the safest health care system in the world, some say there are very slight risks associated with it. We feel that it is responsible to let you know: 1. While extremely rare, there have been reports of ligament sprains, and even rib fractures reported; 2. There have been rare reports of disc injuries although no clinical scientific study has ever demonstrated chiropractic care to be the cause. Chiropractic care has been proven to be both, clinically and cost effective. The risk of injuries and complications is so small that chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world. Compared to traditional medical/drug/surgical care, which has a yearly death rate of approximately 200,000 people in North America, Chiropractic is your safest health care system.

I have read and understand the above consent, and have had the opportunity to discuss it with my chiropractor. I have been informed and fully understand that Chiropractic care is not a treatment of any disease or condition. I consent to the care recommended by my chiropractor and extend this consent to include all doctors of this Chiropractic & Wellness Center. This consent applies to all present and future care for me and my family.

Signature ____ Date _________

Signature of Parent {for Minor} ____________________________________ Date ________

FINANCIAL RESPONSIBILITY

Family First Chiropractic & Wellness

In return for services rendered to me by Family First Chiropractic & Wellness, I promise to pay in accordance with bills or invoices presented. If I participate in a health benefit plan, I acknowledge financial responsibility in accordance with the terms of the plan for any services rendered that my plan may exclude from payment for any reason.

Assignment of Benefits – I understand that Family First Chiropractic and Wellness Center is not a provider for my insurance company or any insurance company. I understand that benefits I may try to claim form my insurance company for services rendered at this Wellness Center quoted from my insurance carrier are only an estimate and not a guarantee of payment.

Medicare – I acknowledge that Family First Chiropractic & Wellness is NOT a Medicare Provider and DOES NOT accept Medicare Benefits.

Release of Medical Information and Records
By signing below I authorize Family First Chiropractic & Wellness to release all medical information and/or records requested by my insurance company or any referring doctor. By signing below I also authorize Family First Chiropractic & Wellness to use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided and any administrative operations related to treatment or payment.

Acknowledgment of Privacy Practices
I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Family First Chiropractic & Wellness, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

I have read and fully understand the above statements and I authorize trained and licensed personnel to administer treatment as deemed necessary.

____ ____________________
Signature of Patient (or legal Guardian) Date