A hands-on approach to health & he
1075 Ann Arbor Rd, Plymouth, MI 48170 | 734.454.5600

ADOLESCENT HEALTH HISTORY
(13-17 years)

We are excited that you have chosen Wellness Center of Plymouth to assist in the health and wellness needs of you and your family! Let us know if there is anything we can do to make you more comfortable.

Please fill out this form as completely as possible. Please print.

PERSONAL INFORMATION

Child's Name_____ What you prefer to be called_____
Home Address_____ City_____ State_____ Zip_____
Age_____ Date of Birth____/____/_____ Sex___ Height_____ Weight_____ SS#_____
Whom may we thank for referring you to our office? _____

FAMILY INFORMATION:

Father's Name_____ Mother's Name_____
Father's Cell Phone (_____) _____ Mother's Cell Phone (_____) _____
Father's Work Phone (_____) _____ Mother's Work Phone (_____) _____
Home Phone (_____) _____ E-mail _____
Parent's Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed □ Living Together

REASONS FOR SEEKING CHIROPRACTIC CARE

At Wellness Center of Plymouth, we focus on your ability to be healthy.
Our goals are to first address the issues that brought you into this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future.

Please briefly describe the main concern that you would like us to address:

_____
_____

Are these concerns affecting your quality of life? (check all that apply)

□ Work □ School □ Exercise/Sports □ Driving
□ Walking □ Eating □ Sleep □ Sitting
□ Hobby – please list_____

When did the issue start? _____ What brought it on? _____
Have you had this problem before? □ No □ Yes – please explain _____
If you are experiencing pain, where is it located? _____
Describe the symptoms: □ Sharp □ Dull □ Achy □ Numb □ Tingling □ Stabbing □ Throbbing
Does the pain travel/radiate anywhere? □ No □ Yes – please describe_____
Since the problem started, it is? □ About the same □ Getting better □ Getting worse
What makes it worse? □ Standing □ Walking □ Sitting □ Lying □ Bending
□ Lifting □ Twisting □ Coughing □ Other _____

Patient Name: _____ Date: _____ Pt# _____

What have you done for this condition that has helped you feel better? _____
What have you done for this condition that was of no help? _____
Are you currently wearing: □ Heel lift R/L □ Arch Supports

HEALTH CARE PRACTITIONER HISTORY

Other doctors seen for ***this condition***: □ Chiropractor □ Medical Doctor □ Other – please list_____
1. Name_____ City_____ Date_____
X-rays taken □ No □ Yes _____ Special tests done □ No □ Yes _____
Diagnosis_____ What was done_____

2. Name_____ City_____ Date_____
X-rays taken □ No □ Yes _____ Special tests done □ No □ Yes _____
Diagnosis_____ What was done_____

Have you ever had chiropractic care? □ No □ Yes Name of D.C._____
How long under care? □ _____days □ _____weeks □ _____months □ _____years
Date of last visit_____ Why was care stopped? _____
Are you satisfied with the care your child received there? □ No □ Yes

Have you consulted or do you regularly consult any of the following providers? (check all that apply)
□ Medical Physician □ Naturopath □ Acupuncturist □ Homeopath
□ Massage Therapist □ Psychotherapist □ Optometrist □ Dentist
Reason why_____

Name of primary care physician_____ City _____
Date of last visit ____/____/_____ Reason _____

YOUR HEALTH PROFILE

The primary system in the body which coordinates health is the CENTRAL NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Chiropractors are specialists trained in "early detection" of injury to the SPINE & NERVE SYSTEM.

The information below will help us to see the types of PHYSICAL, CHEMICAL & EMOTIONAL stresses you have been subjected to and how they may relate to your present spinal, nerve and health status.

GENERAL HISTORY
Please mark all symptoms you have ever had, even if they do not seem related to the current problem.

□ Dizziness	□ Leg problems	□ Fainting	□ Neck pain
□ Headache	□ Arm problems	□ Back aches	□ Loss of balance
□ Loss of smell	□ Poor posture	□ Scoliosis	□ Nervousness
□ Behavioral problems	□ Asthma	□ Poor appetite	□ Stomach upset
□ Fatigue	□ ADD/ADHD	□ Irritability	□ Tension
□ Sleeping problems	□ Stiff neck	□ Muscle pain	□ Growing pains
□ Diarrhea	□ Constipation	□ Fever	□ Bed wetting
□ Cold sweats	□ Lights bother eyes	□ Urinary problems	□ Heartburn
□ Mood swings	□ Menstrual irregularity	□ Menstrual pain	□ Ulcers
□ Trouble walking	□ Seizures	□ Diabetes	□ Cancer _____

Patient Name: _____ Date: _____ Pt# _____

Please list any other **serious medical condition(s)** you have currently or have ever had:

_____

_____

FOR FEMALE ONLY

Are you pregnant? □ No □ Yes Date of last menstrual period ____/____/_____

If **pregnant**: Due date ____/____/_____ Name of OB-GYN _____

If x-rays are recommended, your signature is required (below) to indicate that you are **not pregnant**.

Parent Signature _____ Date ____/____/_____

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine and nerve system.
Please indicate where and how you were birthed.

□ Home □ Natural □ Hospital □ Caesarian section
□ Forceps □ Breech □ Cord around neck □ Prolonged labor
□ Drug induced labor □ Suction □ Do not know

PHYSICAL STRESS: CHILDHOOD THROUGH PRESENT

The minor and often ignored repetitive physical traumas that we have endured are often too numerous to list.

Have you ever been involved in **organized sports** (i.e. football, soccer, baseball, basketball, gymnastics, cheerleading, martial arts, etc.)? □ No □ Yes – please _____

Have you ever been in a **car accident**? □ No □ Yes – please explain _____

_____

Have you ever ever had a **bone fracture or joint dislocation**? □ No □ Yes – please explain _____

_____

Have you ever **hurt/injured** your spine, head, neck, ribs, chest, upper and lower back, pelvis or hips? □ No □ Yes
If yes, state type of injury and date:

_____

_____

Have you had any **other traumas** not described above? □ No □ Yes – please explain _____

_____

Have you ever been **hospitalized**? □ No □ Yes If yes, state reason and dates:

_____

_____

Do you feel your **book bag** is too heavy for you to carry? □ No □ Yes

How many hours per day do you do each of the following?

□ Watch TV _____ □ Use a computer _____ □ Play video games _____

On average how many **hours of sleep** do you get per night? _____

Patient Name: _____ Date: _____ Pt# _____

CHEMICAL STRESS

Chemical stress can occur when a substance that is toxic to the body is breathed, injected, taken by mouth or place on the skin (I.e. food allergies, drug reactions, exposure to chemicals in the air, etc.).
Please answer the following which will reveal exposures you may have had.

Were you vaccinated? □ No □ Yes If yes, did you have a reaction? □ No □ Yes
Have you been exposed to any of the following on a regular basis (past or present)?
□ Toxic chemicals □ Second hand smoke □ Drug therapy
□ Radiation □ Chemotherapy □ Other_____
If yes, please list: _____

Do you have any **food/drink allergies, sensitivities or intolerances**: □ No □ Yes – please list:
_____
Do you presently **consume** any of the following or have you in the past?
□ Caffeine □ Tobacco □ Over the counter drugs □ Prescribed drugs □ Illegal drugs

Please list any **drugs or medications** (prescription or over-the-counter) you are taking and the reason why.
_____ _____
_____ _____

Please list any **vitamins, supplements, herbs, homeopathics**, **etc.** that you are taking and the reason why.
_____ _____
_____ _____

Note: it is imperative that you list all medications as they may have an influence on your care.

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs.

Please indicate if you have experienced any of the emotional stresses below. (check all that apply)
□ Childhood trauma □ Loss of loved one □ Abuse □ Work
□ School □ Parents Divorce □ Illness □ Self-esteem
□ Other _____

Do you have **difficulty concentrating**? □ No □ Yes – please explain: _____
_____

Do you feel **overwhelmed or frustrated**? □ No □ Yes – please explain: _____
_____

Do you get **angry easily**? □ No □ Yes – please explain: _____
_____

ADDITIONAL QUESTIONS

If there is a need for **dietary changes or nutrients**, would you like to be informed? □ Yes □ No
If there is a need for **specific exercises**, would you like to be informed? □ Yes □ No
If there is a need for support in the **emotional/stress** area of health, would you like to be informed? □ Yes □ No
Is there any **specific health topic** you would like more information on? _____

Patient Name: _____ Date: _____ Pt# _____

EXPECTATIONS

I would like to have the following benefits 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
□ Best possible health on all levels

PLEASE READ AND SIGN BELOW

The information I have provided on these forms is correct and accurate to the best of my knowledge. I give Dr. Elizabeth Sisk, Associates and whomever he/she may designate as his/her assistant permission to administer care to my son/daughter as they deem necessary. The initial visit includes a professional and complete health history/consultation and chiropractic examination/evaluation.

Printed Name_____ Signature _____ Date ____/____/_____

Witness Printed Name _____Signature _____ Date ____/____/____

Thank you for choosing Wellness Center of Plymouth!

We look forward to helping you.

Patient Name: _____ Date: _____ Pt# _____