

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)

- | | | | |
|--|---------------------------------|--|----------------------------------|
| <input type="checkbox"/> Work | <input type="checkbox"/> School | <input type="checkbox"/> Exercise/Sports | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Eating | <input type="checkbox"/> Sleep | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> 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.

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

- | | | | |
|---|----------------------------------|---|--|
| <input type="checkbox"/> Home | <input type="checkbox"/> Natural | <input type="checkbox"/> Hospital | <input type="checkbox"/> Caesarian section |
| <input type="checkbox"/> Forceps | <input type="checkbox"/> Breech | <input type="checkbox"/> Cord around neck | <input type="checkbox"/> Prolonged labor |
| <input type="checkbox"/> Drug induced labor | <input type="checkbox"/> Suction | <input type="checkbox"/> 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 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#