**Curley Chiropractic**

**Teenager's Health History Form**

## Personal Data

Today's Date ____________________________

Name____________________________________ Age__________ Date of Birth______________________

Parent's names___________________________________________________________________________

Home Address_____________________________City______________________State_____Zip_________

HomePhone(___)______________________Email-address__________________________________

Cell Phone (___)________________________Cell Provider___________________________________

SS#(opt'l)_______________________________Emergency contact__________________________________

Names and ages of child'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 you're your teenager?_________________________________

_____________________________________________________________________________________

Are these concerns affecting your child'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

**Has 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 which 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 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 checked any of the above please state the **type of injury and date.**

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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 already listed above:___________________________________

## FOR PARENTS

**The following questions pertain to <u>at any point in the patient's life did any of these occur</u>.**
**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 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 experienced any of the following?**

___headaches ___numbness in arm/hands ___foot/ankle/knee pain

___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 child feel?_____________________________

_________________________________________________________________________________

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

_________________________________________________________________________________

Describe any hospital or emergency room stays?____________________________________________

_________________________________________________________________________________

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

______________________________________________________________________________

List any medications your child is currently taking: ________________________________________

______________________________________________________________________________

Is there anything else you think we should know about your child?____________________________

______________________________________________________________________________

## 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 Curley Chiropractic. This consent applies to all present and future care for me and my family

Signature_____________________________________________________Date_______________

Signature of Parent (for minor)_______________________________________Date______________

# FINANCIAL REPSONSIBIILTY

**CURLEY CHIROPRACTIC**

In return for services rendered to me by Curley Chiropractic, 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 Curley Chiropractic may or may not be a provider for my insurance company for services rendered at Curley Chiropractic quoted from my insurance carrier are only an estimate and not a guarantee of payment.

**Medicare**--- I acknowledge that Curley Chiropractic is a Medicare Provider and DOES accept Medicare Benefits.

**Release of Medical Information and Records**

By signing below I authorize Curley Chiropractic to release all medical information and/or records requested by my insurance company or any referring doctor. By signing below I also authorize Curley Chiropractic 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 Curley Chiropractic, 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