WELLNESS CHIROPRACTIC

20 East Blue Hill Road
PO Box 326
Blue Hill, ME 04614
: 207-374-2186
Fax: 207-374-5235
www.mywellnesschiro.com

ADOLESCENT HEALTH SURVEY (SIX TO TWELVE YEARS)

Name: _____ Guardian:_____

Address: _____

City: _____ State:_____ Zip:_____

Home Phone: ____-____-_____ Work Phone: ____-____-_____ Cell Pone:____-_____-_____

Email Address:_____

Date of Birth: _____ Social Security#:_____-_____-_____ Gender: ☐ Male ☐ Female

Please indicate if your child has or ever had any of the following:

Back or neck pain	Y N	Has frequent colds, cough or runny nose	Y N
Pain in legs or arms	Y N	Sinusitis	Y N
Broken bones	Y N	Asthma	Y N
Torticollis (severe head tilt)	Y N	Allergies*	Y N
Headaches	Y N	Eye problems	Y N
Ear Infections	Y N	Nose bleeds	Y N
Tubes in the ears	Y N	Fainting	Y N
Seizure disorders	Y N	Eating difficulties	Y N
Constipation	Y N	Diarrhea	Y N
Upset stomach	Y N	Bed wetting	Y N
Frequent urination	Y N	Skin problems (Eczema, rashes, etc.)	Y N
Diabetes	Y N	Hepatitis	Y N
Rheumatic fever	Y N	Meningitis	Y N
Strep throat	Y N	Childhood diseases	Y N

**If your child has any allergies, please list:*_____

Trauma

Fall from a bicycle, scooter, skate boad, etc.	Y N	Fall down the stairs	Y N
Fall from a significant height	Y N	Motor vehicle accident	Y N
Injuries (bone fracture, burn, cut, etc.)	Y N		

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Emotional Status:
*Please check if your child has or ever had any of the following***:**

Sleeping difficulties	Y N	Anxiety	Y N
Nightmares	Y N	Afraid of new environment	Y N

Family History:
*Does any one in the child's family have***:**

Asthma	Y N	Respiratory allergies	Y N
Food allergies	Y N	Diabetes	Y N
Cancer	Y N		

Lifestyle:
What grade are you in school? _____What hobbies do you have? _____
How heavy is your school bag? _____How many hours of sleep do you get each night? _____
How do you carry your school bag? _____How many hours a day do you watch TV? ____
What sports do you play? _____
How many hours a day do you spend on the computer? _____
How many hours a day do you play video games? _____

Nutrition:
What do you usually eat for breakfast? _____
What do you usually eat for lunch? _____
What do you usually eat for dinner? _____
What snacks do you eat during the day? _____
How much water do you drink during the day? _____
How much milk do you drink during the day? _____
How many sodas do you drink during the day? _____

Immunization Status: ☐Choosing not to immunize ☐All up to date and current
List the immunizations your child has received and any reaction you have observed:

Date	Immunization	Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Previous Health Care:

Name of Pediatrician: _____ Date of Last Exam: _____
Name of Chiropractor: _____ Date of Last Exam: _____

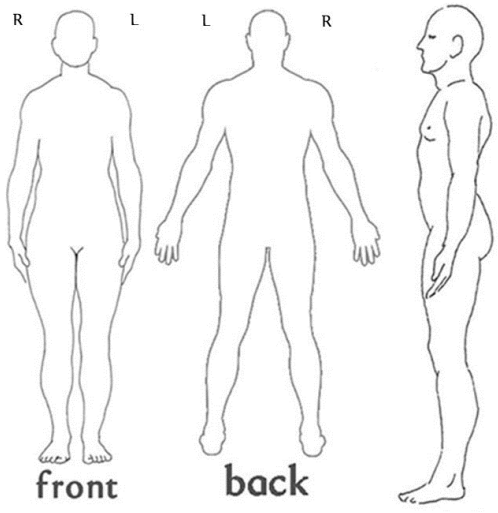
Is your child under medical care for a specific condition? If so, please list the condition and the care received:
_____
_____

Do you have any concerns about your child's health? _____
_____
_____
_____

SUBJECTIVE PAIN ASSESSMENT

PAIN SCALE: *Please circle the number that best describes your overall pain:*

0	1	2	3	4	5	6	7	8	9	10	10+
None		Little			Medium			Severe		Excruciating	



Place and "X" on the drawing to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:
A=Ache
B=Burning
ST=Stabbing
SP= Spasm
N= Numbness
P= Pins and Needles
T=Throbbing

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE: **DATE:**

_____ _____