Teen Confidential Intake Form

Today's Date: _____

Name: _____ Age: _____ Gender: _____
& Preferred Name if different she/her he/him they/them

Birth date: _____
MM /DD / YYYY

Address: _____
Residence and Mailing City Prov. Postal Code

Teen's phone number: _____ Email: _____

Who will set up further appointments for you? ⬜Myself ⬜My parent/guardian

Occupation: _____ Employed by:_____

Emergency Contact: _____ Relationship to contact: _____
Name Contact Number

Have you had previous chiropractic care? ⬜Yes ⬜No Were X-rays Taken? ⬜Yes ⬜ No

Chiropractor/Office name: _____ When was your last adjustment? _____

Medical Doctor's name and phone number: _____
Name Contact Number

Who may we thank for referring you to our office? _____

Parent Info

Parent's Name: _____

Home # _____ Work # _____Ext.____ Mobile #_____

Email: _____

Other parents' Name and contact info:_____
Name Phone Number

Names & ages of other children: _____

Present complaint

_____

_____

_____

What caused the problem? _____

Since the problem started, it is: ⬜ About the Same ⬜Getting Better ⬜Getting Worse

Have you had this problem before? _____

What makes it worse?

Is there anything you can do to relieve the problem? ⬜ Yes ⬜No If yes describe: _____

How frequent is the complaint? ⬜ Constant ⬜ Daily ⬜ Intermittent ⬜ Night Only

How long does it last?_____

It Interferes with: _____

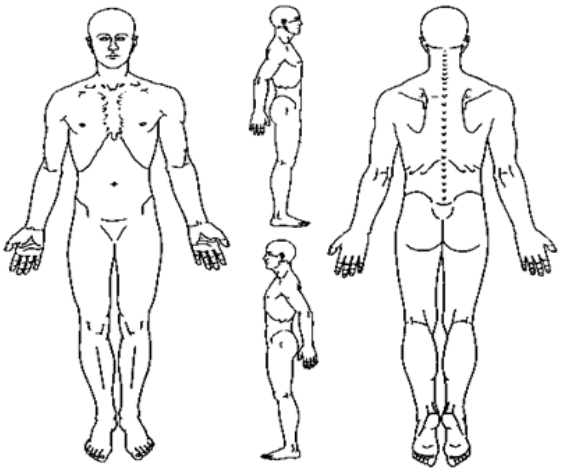
1 2 3 4 5 6 7 8 9 10

Please circle your pain level online above (1=no pain, 10=severe pain)

see diagram on next page

On the diagram, label ALL areas you are experiencing using the appropriate letter below.

A= Aching
B= Burning
N= Numbness
P= Pain
T= Tingling, Pins/Needles
S= Stabbing
T= Tingling
O= Other _____



Please list any major accidents or surgeries you have had: _____
_____
Please list any medications you are taking: _____
_____

In the boxes below please check (X) for all current symptoms and (P) for all past symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches
☐ Migraines
☐ Jaw/TMJ Pain
☐ Stiff Neck
☐ Neck Pain
☐ Broken Bone(s)
☐ Mid back Pain
☐ Low Back Pain
☐ Shoulder Pain
☐ Hip Pain
☐ Pain with Cough/Sneeze
☐ Pins & Needles in Arms
☐ Pins & Needles in Legs
☐ Diabetes

☐ Numbness in Fingers
☐ Numbness in Toes
☐ Tension
☐ Seizures
☐ Epilepsy
☐ Buzzing in Ears
☐ Ear Infections
☐ Sinus Problem
☐ Loss of Smell
☐ Sensitive Eyes
☐ Fever
☐ Asthma
☐ Allergies
☐ Menstrual Irregularities

Menstrual Pain
☐ Hot Flashes
☐ Mood Swings
☐ Irritability
☐ Diarrhea
☐ Constipation
☐ Eating Disorder
☐ Upset Stomach
☐ Heartburn
☐ Ulcers
☐ Problem Urinating
☐ Kidney Problems
☐ Bed Wetting
☐ Concussions

Difficulty Concentrating
☐ Loss of Balance
☐ Dizziness
☐ Fainting
☐ Stroke
☐ Nervousness
☐ Depression
☐ Fatigue
☐ Sleeping Problems
☐ Cold Sweats
☐ Cancer
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Cold Feet
☐ Cold Hands

☐ Other: _____

Lifestyle

Lifestyle choices can impact the way your body recovers. Please answer the following questions for us to determine the correct treatment plan for your case.

On a scale of 1 – 10 describe your stress level (1=none / 10=extreme)
Occupational: _____ Personal: _____

On a scale of Poor, Good, Excellent describe your:
Diet: _____ Exercise: _____ Sleep: _____ General Health: _____

Alcohol use:
☐Yes ☐ No

Recreational Drug use:
☐ Yes ☐ No

Smoking cigarettes:
☐ Yes ☐ No

If Applicable: Menstruation
Hormone changes can impact the way that your body is functioning.

Are you menstruating? ☐ Yes ☐ No
Are there any issues with your cycle? (Normal, cramping, heavy bleeding, headaches, back pain, ir-regularity)

_____

_____

FAMILY HEALTH PROFILE (optional):

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your family: _____

_____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Prior to establishing a treatment plan, the doctor must perform a Chiropractic Examination in order to determine the exact cause of your complaint. During the examination the doctor will perform some procedures or maneuvers intended to reproduce your symptoms which will allow for a better understanding of the nature of your condition and for the development of an appropriate treatment regimen. There is a slight possibility that these maneuvers may temporarily aggravate your symptoms.

_____ _____
Signature of patient Guardian signature

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CONSENT FORM

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

● **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.

● **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.

● **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.

● **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.

● **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

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● Stroke – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

Financial Agreement

Initial Assessment fee $90, subsequent visit $45. Reactivated visit $60. A treatment plan will be discussed between you and the chiropractor based on your individual needs.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____
Name (Please Print)

_____ Date: _____ 20____.
Signature of patient (or legal guardian)

_____ Date: _____20____
Signature of Chiropractor