

ADOLESCENT CASE HISTORY

Exercise Habits

How many days a week do you exercise? _____

What types of exercise do you normally participate in? (please circle all that apply)

walking biking yoga water aerobics
running aerobics pilates weight lifting other _____

Have your exercise habits changed in the past six months? Yes No

If yes, have they: increased decreased

Do you participate regularly in any sports? _____

What sports do you play? _____

Have you ever had injuries related to these sports? Yes No

If yes what injuries? _____

Daily Habits

Do you drink: Coffee Pop Water

How much do you consume in a day? Coffee _____ Pop _____ Water _____

What vitamins do you normally take? _____

How many hours a night do you sleep continuously? _____ Total Hours: _____

Do you sleep soundly and feel rested in the morning? _____

On a scale of 1-10 (1 being least and 10 being most) rate your overall stress level: _____

Other than the 5 hours per day spent sitting in the classroom, do you spend additional prolonged time sitting? Yes no. If yes, is it in front of a computer or TV? _____

How would you rate your diet? (please circle one) poor fair good very good excellent

Do you consume artificial sweeteners? _____ Flavored water? _____

Family History

Does your mother or father have any of the following:

Use a **M** for mother, **F** for father, and **B** for both.

- | | |
|-------------------------|-------------------------------|
| () High Blood Pressure | () Ulcer or Stomach Problems |
| () Heart Attack | () Stroke |
| () Emphysema | () Arthritis-Rheumatism |
| () Seizure-Convulsions | () Mental Illness |
| () HIV Positive | () Thyroid Disease |
| () Asthma | () Circulation Problems |
| () Diabetes | () Cancer |
| () Kidney Disease | |

Health History

Circle any of the following conditions you have suffered from:

- Colic Irregular Sleeping Patterns Night Terrors Seizures Tantrums Ear Infections
Allergies Asthma Headaches Poor Digestion Repeated Infections or Colds
Bed Wetting Learning Disorders ADD or ADHD Dizziness Diabetes
Anxiety Unexplained weight loss Thyroid disorder Other

Health History cont.

Please give approximate dates of any motor vehicle accidents: _____

Please give approximate dates of any other serous injuries: _____

Please list all surgeries: _____

Please list all medications you are currently taking: _____

Current Symptoms

What is your primary reason for this visit? _____

Where specifically is the problem located? _____

When did you first notice the symptoms? _____

How did this condition begin? _____

Is this condition getting progressively worse? _____

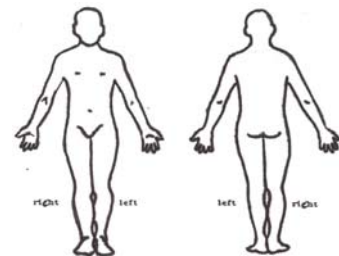
Have you previously experienced this problem? _____

Is the pain constant or does it come and go? _____

Does the pain wake you at night? _____

Have you had any loss of bowel or bladder control? _____

Place an "X" on the drawing below on areas causing you pain.



Please rate **(1-easy, 10-severe difficulty)** your level of difficulty to perform these actions:

_____ Sitting _____ Standing _____ Walking _____ Bending

_____ Typing _____ Lifting _____ Lying Down

Are you experiencing pain? **Please give locations for your specific types of pain**

N=neck **MB**=mid-back pain **LB**=lower back pain **A**=arms **L**=legs

_____ Sharp _____ Throbbing _____ Aching _____ Shooting _____ Burning

Are you experiencing other symptoms? Please state their location.

N=neck **MB**=mid-back pain **LB**=lower back pain **A**=arms **L**=legs

_____ Numbness _____ Tingling _____ Weakness _____ Stiffness

Rate the severity of your pain. **(1-very mild pain or discomfort, 10-severe pain)**

Today 1 2 3 4 5 6 7 8 9 10

Normally 1 2 3 4 5 6 7 8 9 10

At its worst 1 2 3 4 5 6 7 8 9 10

Have you received any medical treatment for your condition? Yes No

What type of treatment? _____

Have you ever received chiropractic care? Yes No

Who was your doctor? _____

When was your last treatment? _____

Is there any other health information that I might need to know? _____

What would you like to see changed about your overall health condition? _____