

## ADOLESCENT HEALTH ASSESSMENT

**Name:** \_\_\_\_\_ **Age** \_\_\_\_ **Date of birth** \_\_\_\_\_  
**Parent's Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Town** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Work phone** \_\_\_\_\_

*Please answer the following questions that are designed to help maximize your child's health. Many types of stress (physical, mental, and chemical) can interfere with your child's growing spine and nerve system. Spinal health is an exciting new concept for many people, so please ask questions.*

**Reason for visit to our office:** \_\_\_\_\_  
\_\_\_\_\_

### Birth and Prenatal History:

**Birth Place:** YHome YHospital YBirth Center Ymid Wife

**Type of Delivery:** YVaginal YC-Section

**Interventions:** YForceps YVacuum Extraction YEpidural

**Complications of delivery:** \_\_\_\_\_

**Medications during delivery:** \_\_\_\_\_

**Ultrasounds during pregnancy:** \_\_\_\_\_

### Feeding:

**Breast fed? YYYN How long? \_\_\_\_ Did he/she nurse equally to each breast? YYYN**

**Is there any intolerance or allergy to foods? YYYN List** \_\_\_\_\_

**Does your child eat: sweets \_\_\_\_ Foods with artificial sweeteners \_\_\_\_ Drink soda: \_\_\_\_**

**Does your child take vitamins or supplements? \_\_\_\_ Which ones? \_\_\_\_\_**

### Developmental Milestones:

**Did your child reach developmental milestones crawling, walking, and talking at the appropriate ages? YYes YNo**

**Onset of menstruation:** \_\_\_\_\_

Please complete reverse side => => =>

**According to the National Safety Council approximately 50% of infants fall headfirst from a high place (bed, couch, changing table) during their first year of life. Has this happened to your child?** \_\_\_\_\_

**Has either a doctor or hospital seen your child on an emergency basis?** \_\_\_\_\_  
**Explain:** \_\_\_\_\_

**Has your child had surgery?** \_\_\_\_\_

**Does your child have any learning challenges?** \_\_\_\_\_

**Which sports/activities does your child participate in?** \_\_\_\_\_

**Check any of the following your child has had during the past 12 months:**

**Y**Ear infections **Y**Scoliosis **Y**Chronic cold **Y**Asthma **Y**Allergy **Y**Colic **Y**Eczema  
**Y**Psoriasis **Y**Diabetes **Y**Bedwetting **Y**Seizures **Y**Visual impairment **Y**ADD/ADHD  
**Y**Recurring fever **Y**Digestive problems **Y**Temper tantrums **Y**Growing pains  
**Y**Headache **Y**Subluxation **Y**Back aches

**Has your child had: Y**Chicken pox **Y**Rubella **Y**Rubeola **Y**Mumps **Y**Measles **Y**Roseola  
**Y**5<sup>th</sup> s Disease **Y**Whooping Cough - other \_\_\_\_\_

**Number of prescription drugs your child has taken:**  
**Over the past 12 months?** \_\_\_\_ **In his /her lifetime?** \_\_\_\_  
**Types:** \_\_\_\_\_

**Number of non-prescription drugs your child has taken:**  
**Over the past 12 months?** \_\_\_\_ **In his/her lifetime?** \_\_\_\_  
**Types:** \_\_\_\_\_

**We understand that not all parents wish to immunize their children. Has your child been immunized? \_\_\_\_\_ If yes, what age was the first vaccine? \_\_\_\_\_ Has your child ever had a reaction of any kind to an immunization? \_\_\_\_\_ If yes what type of reaction?** \_\_\_\_\_

**I hereby authorize the doctors at this office to examine and provide care for my child.**

**Signed:** \_\_\_\_\_ **(Parent or Guardian) Date:** \_\_\_\_\_