TAILOR MADE WELLNESS CLINIC

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CHIROPRACTIC
Young Adult Intake Form
(13 – 17 years)

Alberta Healthcare # (required for clinic paperwork purposes)	

Personal Information

Name			Date
Address			
City, Province			Postal Code
Home Phone.			OK to leave messages? ☐ Yes / ☐ No
Birth Date:		Gender:	
Age:	Height:	Weight:	☐ Right handed / ☐ Left handed

Emergency Contact Information

Mother's name:	
Home phone:	Work phone:
Father's name:	
Home phone:	Work phone:
Other/Legal guardian:	Relationship:
Home phone:	Work phone:
Name of family doctor:	

Medications (Please list medication names where possible.)

☐ Antibiotics	☐ Antidepressants	☐ Bronchodilators (Asthma)
☐ Birth control	☐ Muscle relaxants	☐ Cold medication

☐ Anti-inflammatories / Pain killers
- ☐ *Aspirin / ASA (acetylsalicylic acid) Bufferin*
- ☐ *Advil / Ibuprophen*
- ☐ *Tylenol / Anacin / Acetominophen*
- ☐ *Corticosteroids (prednisone, asthma drugs, etc.)*
- ☐ *Robaxin / Robaxisal / Robaxacet / Robax Platinum, etc.*

☐ Non-prescription/recreational ☐ Other

☐ I am currently not taking any medications

Vitamins / Herbs / Supplements (Please list all.)	Allergies (Please list.)

Primary concern

What is your <u>primary concern</u> today?

Please describe the character of your pain:

☐ Dull	☐ Aching	☐ Stabbing	☐ Burning	☐ Pins & needles
☐ Sharp	☐ Pulling	☐ Nagging	☐ Throbbing	☐ Weakness

Date of onset/duration?

Is this a Motor Vehicle Accident Case? ☐ Yes / ☐ No

General Health History			
Please check all additional concerns that apply: **How long?**		**How long?**	
☐ Headaches / Migraines		☐ Arm/hand pain, numbness, tingling	
☐ Neck pain, soreness or stiffness		☐ Chest wall pain	
☐ Upper back pain, soreness, stiffness		☐ Shoulder pain	
☐ Lower back pain, soreness, stiffness		☐ Leg/foot pain, numbness, tingling	
☐ Hip / groin pain		☐ Other	
Have you ever been treated by a Chiropractor for any condition? ☐ Yes (When?) / ☐ No			
If yes, Doctor's name: Were treatments helpful? ☐ Yes / ☐ No			
Have you ever been treated by:			
☐ Physiotherapist	☐ Naturopathic doctor	☐ Massage therapist	
☐ Allergist	☐ Specialist	☐ Podiatrist	
Do you exercise			
☐ 1-2 times weekly		☐ I lift weights (gym/home)	
☐ 3 or more times weekly		☐ I do cardiovascular workouts	
☐ I do NOT exercise		☐ I stretch regularly	
Sports involvement			
☐ Badminton	☐ Golf	☐ Music (instrument:)	
☐ Baseball	☐ Gymnastics	☐ Soccer	☐ Weight lifting
☐ Basketball	☐ Hockey	☐ Swimming	☐ Wrestling
☐ Dancing	☐ Horse riding	☐ Tennis	☐ Other
☐ Figure skating	☐ Martial arts	☐ Track & field	
☐ Football	☐ Ringuette	☐ Volleyball	
Injuries / History			
Have you ever been fitted for orthotics? ☐ Yes / ☐ No		Are you wearing them now? ☐ Yes / ☐ No	
Have you ever broken any bones? ☐ Yes / ☐ No If yes, please list:			
Have you ever had a fall that required chiropractic or medical attention? ☐ Yes (When?) / ☐ No			
Have you ever been knocked unconscious? ☐ Yes (When?) / ☐ No			
Have you ever been involved in a motor vehicle accident? ☐ Yes (When?) / ☐ No			
Have you ever had an injury involving:	☐ Athletic injury (When?)	☐ Motorcycle (When?)	
	☐ Bicycle (When?)	☐ Snow mobile (When?)	
	☐ Horse (When?)	☐ Other (When?)	
Have you ever been told you have unusual skeletal changes (eg: scoliosis, unusual vertebra, short leg, etc.?) ☐ Yes (When?) / ☐ No			
Did you have any prior health problems that have been corrected or you've outgrown? ☐ Yes / ☐ No If yes, please explain:			
Sleep habits			
Are you sleeping on:	☐ Box spring mattress	☐ Water bed	
	☐ Foam mattress	☐ Other	
Type of pillow:	☐ Feather	☐ Foam	
	☐ Contour	☐ Buckwheat	
	☐ Other		
Normal sleep pattern:	☐ Poor, awaken tired	☐ Rested less than 6 hrs.	
	☐ Rested after 6-8 hrs.	☐ Need more than 10 hrs.	
	☐ Tend to sleep flat on stomach		

Quadruple Visual Analogue Scale

Please circle the number which best describes the question being asked. NOTE: If you have more than one complaint, please answer the questions for each complaint individually and indicate which score is for which complaint.

Example:

	Headache		Neck					Low Back	
1	(2)	3	(4)	5	6	7	8	(9)	10

What is your pain RIGHT NOW?

1	2	3	4	5	6	7	8	9	10

What is your TYPICAL or AVERAGE pain?

1	2	3	4	5	6	7	8	9	10

What is your pain AT IT'S BEST? (IE: How close to "0" does your pain get at it's best?)

1	2	3	4	5	6	7	8	9	10

What percentage of your awake hours is your pain at it's best? _____

What is your pain AT IT'S WORST? (How close to "10" does your pain get at it's best?)

1	2	3	4	5	6	7	8	9	10

What percentage of your awake hours is your pain at it's worst? _____

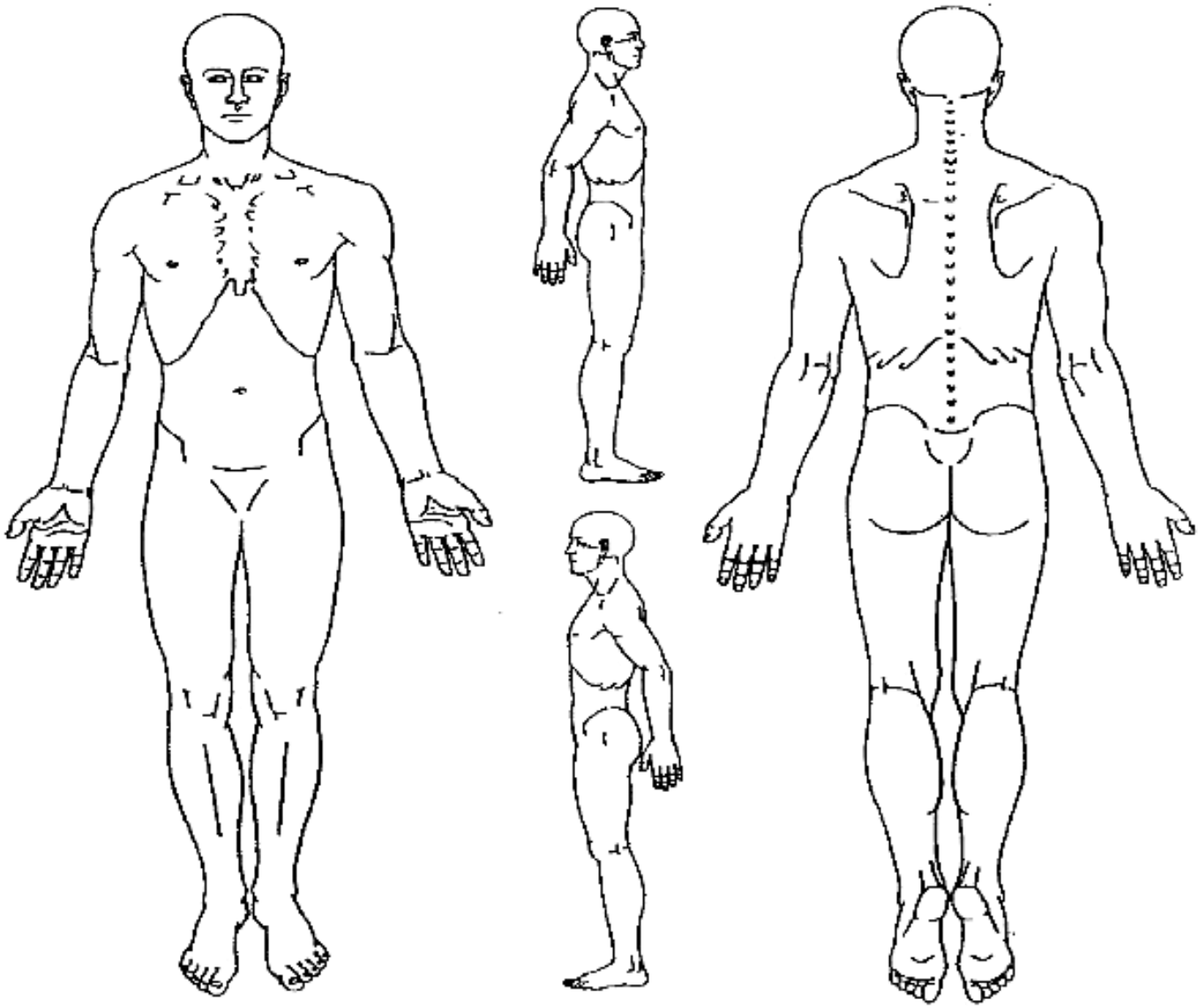
Pain Drawing

It is important that your Chiropractic Doctor knows where you have stiffness, numbness, tingling and any type of pain. Please mark the areas on the figures below that correspond to any pain or altered sensation you're experiencing.

1. Show area(s) of pain or unusual feeling. If the pain you're experiencing travels or "shoots" use arrows to indicate how far it travels.

2. Use the appropriate symbols to mark the area(s) on this body where you feel the described sensations. Include all affected areas.

Numbness	N N N N N	Tingling	T T T T T
Stiffness	S S S S S	Pins and Needles	P P P P P
Burning	X X X X X	Aching	A A A A A
Stabbing	/ / / / / /		



Signature

Patient's signature