EXODUS HEALTH CENTER
Dr. David Jockers/ Dr. Shannon Good/ Dr. Andrew St. Bernard

INDIVIDUALIZED ADOLESCENT HISTORY FORM

IT'S ALL ABOUT YOUR UNIQUENESS

PATIENT DEMOGRAPHICS
HR#:_______________

Childs Name____ Today's Date ____/____/___

Date of Birth ____/____/_____ Current Height: ___________Current Weight: ______ Age: _________

Address
____

City ________________ State _____ Zip _______________ Phone (Home) ________________

Mothers Name: ___________________Mother's Mobile _____________________DOB___/___/___

Fathers name: ___________________Father's Mobile______________________DOB ___/___/___

Pediatrician/Family MD ______________________________City & State ______________________

Last Visit: ___/___/___ Reason for visit:____

Who is responsible for this bill? ____

☐ Other (please explain):

Purpose of this visit: ____Wellness Check ____Injury or Accident ____Other Health Challenge

If your adolescent is experiencing ***Pain/Discomfort/ please identify , where and for how long?***

Date ___/___/___

____

____

____

Did the problem start ____Gradual ____Sudden _____Unknown

PRESENT HEALTH CHALLENGE (S):

For what health challenge(s) is your child here?

____

____

____

What do you feel is the cause of your child's problem?

____

____

____

When did you first notice this sign of body dysfunction?

____

____

____

Ever had this problem **before**? __________NO ____________YES

If yes when? ____

How is this problem **NOW:** ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ On & Off

If yes, why do you think so?

____

____

What are the most significant measures you have taken to date to improve your child's present health challenge?
Please list all the healthcare practitioner's seen, treatments rendered, and any results experienced.

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____

Please list the (3) most significant stressful events in your child's life from the most recent to the most distant. Are any of these situations continuing to impact his/her life? If yes, please explain clearly.

____

____

____

Please list any and all other concerns regarding your child's health and whether or not you feel they are related to your child's primary reason for being seen in our office today.

____

____

____

____

1. Has your child ever sustained an injury playing organized sports? _______ If yes; please explain

____

____

____

____

2. Has your child ever sustained an injury in an auto accident? _______ if yes, please explain

____

____

____

____

HAS YOUR CHILD EVER SUFFERED FROM: *CHECK ALL THAT APPLY*

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADH
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Allergies
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Asthma
☐ Scoliosis	☐ Anemia	☐ Colds/Flu	☐ Walking Trouble
☐ Bed Wetting	☐ Colic	☐ Broken Bones	☐ Sleeping Problems
☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall from crib	☐ Fall off swing
☐ Fall off bicycle	☐ Fall from high chair	☐ Fall off slide	☐ Fall down stairs
☐ Fall from changing table	☐ Fall off monkey bars	☐ Fall off skateboard/skates	☐ Other:

Did you know that the persistent use of antibiotics can lead to an early onset of gastrointestinal tract distress leading to overgrowth of intestinal yeast? Did you also know that chronic use of antibiotics can lead to antibiotic resistant bacteria?

Number of doses of antibiotics has your child taken: __________in the past 6 months _____________in his/her lifetime

Please list any and all prescription medications that your child is presently using and has used on more than one occasion. Please reflect carefully as your child's present health state may be related directly or indirectly to the treatment of a past problem.

____

____

____

Vaccination History:____

PRENATAL HISTORY:

Type of birth attendant: OBGYN CNM LAY MIDWIFE

Location of birth: ____________Home ______________Birthing Center ______________Hospital

Complications During Pregnancy: _______NO _________YES List:_________________________

Ultra Sounds During Pregnancy: _________ NO __________YES Number:____________________

Medications During Pregnancy/ Delivery:____________ NO _______________ YES LIST:______________

Birth Intervention: ____________Forceps ______________Vacuum ____________Caesarian: Planned or Emergency

Complications during Delivery: ______________NO ________________ YES LIST:______________

Genetic Disorders or disabilities: ____________NO ________________YES LIST:_______________

Cigarette or Alcohol Use during Pregnancy:_______________NO __________YES

Breast fed:________ NO _________YES How long? __________Formula Fed:__________NO __________YES How long?___________

CHILDHOOD DISEASES:

Chicken Pox	NO/YES	AGE:_____________	**Mumps**	NO/YES	AGE______________
Rubella	NO/YES	AGE:_____________	**Whopping Cough**	NO/YES	AGE:_____________
Rubeola	NO/YES	AGE:_____________	**Other:**	NO/YES	AGE:_____________

According to the National Safety Council, Approximately 50% of all children Fall head first from a hight place during their first year of life (ie: a Bed , changing table, down stairs, etc) Was this the case with your Child?
_______No _______Yes

Has your child ever been hospitalized? _____ Yes _____No

If yes, why and when? (Please list in chronological order)

____

____

____

DAILY ACTIVITES INVENTORY

How many hours of sleep a night does your child get?_________ Quality: Poor Fair Good

How many hours of screen (computer, phone ipad ,TV) time does your child participate in daily?_______________

How many Hours of home Work does your child have per day?____

How many hour of physical activity does your child get per day?____

Please list the (3) most common foods eaten by your child each day.

____

____

____

How many times per month does your child eat fast food? __________
What type?

____

What is the primary beverage consumed by your child?

____

How much water does your child drink each day?

____

Does your child drink soda? ___ Yes ___ No If yes, how much on a daily basis?

____

Does your child consume artificial sweeteners such as those found in sugarless, fat free products? __ Yes __No

If yes, what type of artificial sweeteners does your child use?

____

Has your child exhibited any tolerance and/or allergy to any specific food? ___Yes ___No
If yes, please list all foods. ____

____

____

Has your child been tested for allergies? ___Yes ___No

If yes, how were the tests performed?

____

What were the results? ____

____

If your child does have an allergy, how does it present itself? (Skin rash, hives, ENT/respiratory, digestive symptoms)

____

____

____

Has your child received treatment for any type allergy? ___Yes ___No
If yes, what type of treatment?

____

____

____

I understand that I am directly and fully responsible to EXODUS HEALTH CENTER for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ **Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.**

_______________________________________ _________________________
Parent or Legal Guardian's Signature DATE

Doctor Signature ___________________________ DATE____________________