JOHNSON CHIROPRACTIC CLINIC
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Teen Health Profile

Patient # __________

Date: ________________________ Name: ________________________________

Address: ________________________________ Phone: (*home*) ___________________________

________________________________ (*work*) ___________________________

Date of Birth ____________________________ Occupation: ____

Marital Status: single married divorced separated widowed other

Children: yes no How many? ____________

How did you discover the Johnson Chiropractic Clinic? ____

If referred, the name of the person who referred you: ____

Please complete this general health history survey, as it will provide your doctor with information to better understand your history, your present and long term needs.

Part 1: Your Health Concerns

1. What is the reason you have come to our office today? ____
2. When did this situation or concern begin?____
3. Have you done anything about this situation or concern or obtained any advice or treatment for it? .... Yes No
4. If yes, what were you told? ____
5. What was done? ____
6. Did that seem to work? ____
7. How aware of this are you during the day? 0 1 2 3 at night? 0 1 2 3

   0 - not aware, 1 - slightly aware, 2 - mostly aware, 3 - always aware

8. Is there any time, or activity you can be involved with when you totally or almost forget about this condition, symptom or concern?____
9. Is there any time of day or activity which makes you aware of it? ____
10. What are you doing in your life now that is different from what you would be doing if you did not have this condition/symptom? ____

Part 2: Health/Trauma/Medical/Chiropractic and Healing History

1. Have you ever injured your spine (neck, head, back, hips)? .... Yes No

   Date of most significant injury: ____

   What happened? ____

   Date of most recent injury: ____

   What happened? ____

2. Have you had a work/vehicular accident related injury? .... Yes No

   Please describe ____

3. Please list medications (prescription or non-prescription) you have taken within the past 60 days:

   ____

4. In the past, have you taken other medications for a period of more than 3 months .... Yes No

   What did you take? ____

   What was the reason for taking this medication? ____

Name:____________________

5. Have you had any spinal x-rays, cat scans or MRI of your spine or head? .... Yes No

If yes...when? ____________________ where? ____________________

What were you told about them? ____________________

6. Have you had any surgeries? Please explain ____________________

7. Have you broken any bones, or significantly sprained part of your body? .... Yes No

Please explain ____________________

8. Please list any herbs, nutritional supplements or natural home remedies you take regularly: ____________________

9. Has your spine ever been professionally adjusted by a chiropractor? .... Yes No

By whom? ____________________ When? ____________________

Why did you go?____________________

Are you still going? Yes No

Were you pleased? Yes No

Does your family receive chiropractic care? Yes No

10. Describe your regular exercise and leisure activities ____________________

11. How many hours of sleep do you get per night? _______ what hours? From ____________ to ____________

Do you have any difficulty falling to sleep .... Yes No

Do you often nap or feel sleepy during the day? .... Yes No

Do you awaken refreshed and rested .... Yes No

12. Describe a typical day's diet, including snacks and drinks:____________________

If possible (if it was a typical day) list what you had to eat yesterday: ____________________

Do you crave any certain foods (or flavour) on a regular basis?

If yes, please list ____________________

13. What is your daily intake?

Water ____________________ounces Coffee (or other caffeinated drinks) ____________________ ounces

Alcohol ____________________ounces - type (beer, wines, liquor) ____________________

Tobacco ___________ packs per day - type ________________ How long have you been a smoker?___________

Have you quit smoking? ____________________ when? ____________________

Recreational drugs:________________ - type ____________________ quantity ____________________

Email: ____________________

I give **express consent** to Johnson Chiropractic Clinic for email contact such as birthday greetings and our newsletter and to notify me of special offers and events. I can withdraw my consent at any time. This consent does not apply to statements, reminders or appointments lists, these notifications are covered under implied consent and do not need express consent.

____________________ ____________________

Patient's signature *Date*

(If you are completing this online please complete the Wellness Check)