TEEN INTAKE PACKET

Patient Demographics

Name:_____ Date of Birth:_____-_____-_____

Age:_____ Male / Female Current Height:_____ Current Weight:_____

Address:_____ City:_____ State:_____ Zip:_____

Mothers Name:_____ Mothers Cell Number: _____

Fathers Name: _____ Fathers Cell Number: _____

Health History

Please tell us the condition(s) you are seeking chiropractic care for: Primarily: _____

Secondarily: _____ Third: _____ Fourth: _____

On a scale of 0 to 10, with 0 being no pain, rate your above conditions by circling the number.

Primary	0	1	2	3	4	5	6	7	8	9	10
Secondary	0	1	2	3	4	5	6	7	8	9	10
Third	0	1	2	3	4	5	6	7	8	9	10
Fourth	0	1	2	3	4	5	6	7	8	9	10

About when did the symptom(s) begin? _____ Have you had the symptom(s) before? □ Yes □ No

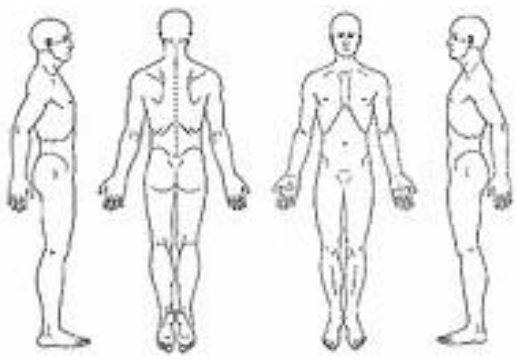
When is the symptom(s) at worst? □ First thing in the morning □ Mid-day □ Afternoon □ Evening □ Same throughout the day

Is your symptom(s): □ Constant □ On and off throughout the day □ On and off throughout the week

What activities make your symptom(s) worse? _____

What, if anything, relives your symptom(s)? _____

Place an X on the diagram below where you are experiencing any pain, numbness, tingling or other symptoms.



Is this condition(s) due to an injury? □ Yes □ No How did the injury happen? _____

Have you tried another form of treatment? □ Yes □ No If yes, what? _____

How long ago did try it? _____ Where the results favorable? □ Yes □ No

Have you received chiropractic care in the past? □ Yes □ No If yes, when was your last adjustment? _____

What was the name of your previous chiropractor or chiropractic office? _____

Please list all current medications:_____

_____

Please list any past surgeries: _____

_____

Have you ever suffered from (please mark Y for YES and N for NO)

___ Headaches	___ Orthopedic Problems	___ Digestive Disorders	___ Behavioral Problems
___ Dizziness	___ Neck Problems	___ Poor Appetite	___ ADD/ADHD
___ Fainting	___ Arm Problems	___ Stomach Aches	___ Raptures/Hernia
___ Seizures/Convulsions	___ Leg Problems	___ Reflux	___ Muscle Pain
___ Chronic Earaches	___ Backaches	___ Diarrhea	___ Sinus Trouble
___ Poor Posture	___ Hypertension	___ Asthma	___ Scoliosis
___ Anemia	___ Cold/Flu	___ Walking Trouble	___ Bed Wetting
___ Colic	___ Broken Bones	___ Sleeping Problems	___ Fall off Bicycle/Skateboard/Skates

___ Other: _____

Physical Activity Level

How often do you exercise? □ None □ 1-3 times a week □ 4-7 times a week

What kind of exercise do you do? □ Bicycling □ Cross Fit □ Gym □ Pilates

□ Recreational Sports □ Running □ Walking □ Yoga □ Other:_____

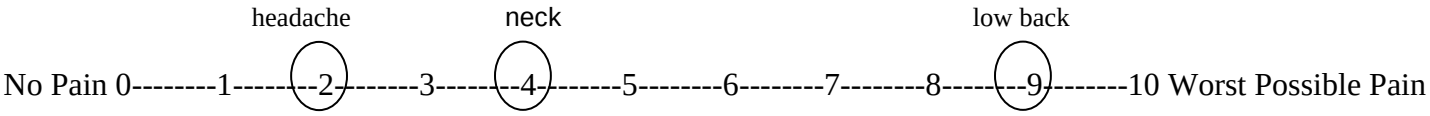
Do you… □ Sit more than 4 hours per day □ Drive more than 2 hours per day

QUADRUPLE VISUAL ANALOGUE SCALE

INSTRUCTIONS: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference.

EXAMPLE:



1. What is your pain RIGHT NOW?

No Pain 0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10 Worst Possible Pain

2. What is your TYPICAL or AVERAGE pain?

No Pain 0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10 Worst Possible Pain

3. What is your pain level AT ITS BEST?

No Pain 0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10 Worst Possible Pain

4. What is your pain level AT ITS WORST?

No Pain 0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10 Worst Possible Pain

5. What percentage of your awake hours is your pain at its worst? _____%

_____ _____

Patient Name Date

FOR OFFICE USE PLEASE DO NOT WRITE BELOW THIS LINE **FOR OFFICE USE PLEASE DO NOT WRITE BELOW THIS LINE**

#1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 =_____

< 50 Low Intensity, > 50 High Intensity

Notice of Privacy Practices

Our office is required to notify you in writing that, by law, we must maintain the privacy and confidentiality of your personal health information. In addition we must provide you with written notice concerning your rights to gain access to your personal health information and the potential circumstances that our office is permitted to, legally, disclose information about you to a third party without your authorization. If you wish to keep a copy of this form for your records, please inform the front desk.

A. Your personal health information can be used without your authorization for -

• Treatment – to conduct, plan, and direct your treatment and follow-up with any other health care providers who may be involved with your case

• Payment – to collect payment from insurance companies or other collateral sources

• Emergencies – in the event of an emergency we may contact a family member

• Inadvertent Disclosures – due to the nature of our semi-open adjusting areas individuals may overhear conversation. In the event you need to discuss a confidential matter with the doctor we can schedule a consultation in a private room

• Change of Ownership – in the event the practice is sold, the new owner will have access to your personal health information

• Public Interest – when your information is requested for by statute, regulation, or court order

B. You have the right to:

• Receive ONE copy of your records at no charge when adequate notice is given (2 business days

• Receive a paper copy of the Detailed Privacy Notice

• Requesting mailings be sent to an address different than that of your residence

• An account of who your personal health information has been disclosed to per the above mentioned section A

• Request restrictions to whom we disclose your personal health information to per the above section A, though ADIO Chiropractic is not required to comply

I, _____ have read and fully understand the above statements.

_____ _____

Parent or Legal Guardian's Signature Date