Confidential Patient Introduction
Age 5 - 18

westwood
TOTAL HEALTH

Personal Information

Name:_____ Date:_____

Address:_____City:_____

Postal Code:_____ Phone#:_____ other:_____

Birthdate:_____ Age:_____

Mother's Name:_____ Father's Name:_____

Who may we thank for referring you to our office?_____

Chief Complaint and Spinal History

Please describe chief health complaint:_____

How long have you had this condition?_____

Activities/Sports Participated in:_____

Are you taking medication? YES NO Please list medications:_____

Spinal subluxations (spinal misalignments) can be caused by traumas such as motor vehicle accidents, falls, heavy lifts etc. Please list below any falls or accidents that may apply (with approximate dates).

_____

_____

Please list any surgeries (with approx. dates) _____

Have you had previous Chiropractic care? YES NO Dr._____

Other Health Concerns:_____

_____

FAMILY HEALTH INFORMATION

Many health problems are the result of hereditary spinal weaknesses. Information regarding family members will give us a better picture of your total health. Please list family members who have any health problems:

NAME	Relationship	Health Problem
_____	_____	_____
_____	_____	_____
_____	_____	_____

CHILDHOOD DISEASES

Chicken Pox _____ German Measles_____

Mumps _____ Whooping Cough_____

Measles _____ Other _____

HAVE YOU SUFFERED FROM?

___ Dizziness	___ Convulsions	___ Paralysis	___ Muscle Jerking
___ Fainting	___ Nose Bleeds	___ Anemia	___ Neck Pain
___ Allergies	___ Chest Pains	___ Constipation	___ Hyperactivity
___ Headaches	___ Tuberculosis	___ Diarrhea	___ Poor Behavior
___ Colds/Flu	___ Heart Trouble	___ Back Ache	___ Hernia/Rupture
___ Sore Throat	___ Growing Pains	___ Fatigue	___Foot Problems
___ Digestive Problems	___ Bronchitis	___ Bed Wetting	___ Sinus Trouble
___ Chronic Earache	___ Hypertension	___ Asthma	___ Broken Bones
___ Walking Problems	___ Arthritis	___ Leg Problems	___ Tonsillitis
___ Rheumatic Fever	___ Joint Problems	___ Poor Appetite	___ Other_____

HAVE YOU EVER:

Been hospitalized (other than surgery)	_____ YES	_____ NO
Been treated for a spine or nerve disorder:	_____ YES	_____ NO
Used a cane, crutch or other support:	_____ YES	_____ NO
Been knocked unconscious:	_____ YES	_____ NO
Fractured a bone:	_____ YES	_____ NO

DATE OF LAST:

	Within 12 Months	Over 12 Months
Physical Exam	_____	_____
Spinal X-Ray	_____	_____
Blood Test	_____	_____
Urine Test	_____	_____

FOR WOMEN ONLY:

Date of last period: _____ Could you be pregnant? YES NO MAYBE

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this clinic and its doctor(s) to administer care as they deem necessary to my daughter/son/ward. I realize that I am responsible for all fees charged by this clinic and agree that I will pay for all services as they are performed.

SIGNATURE:_____

WITNESSED:_____ DATE:_____

Our mission is to help as many people as possible express and maintain their optimal health potential…naturally without drugs or surgery, with the highest quality Chiropractic care.

westwood
TOTAL HEALTH