

Adolescent Admittance Forms (12-17 Years of Age)
TO BE COMPLETED BY PARENT/GUARDIAN

Patient's Name: _____
Birth Date: _____ Age: _____ Sex: _____ Height: _____ Weight _____

Alberta Health Care #: _____

Mother's name: _____ Father's name: _____

Address: _____ City: _____ Prov: _____ P.C. _____
Home phone: _____ Mother's work: _____ Father's work: _____

Contact Email Address: _____

Automated Reminders: Please choose which you prefer
Email: Email 1 day before. Email 2 days before.

Motor Vehicle Accident (if applicable)

Are you seeking treatment for a Motor Vehicle Accident? (circle) Yes / No
Date of Motor Vehicle Accident: _____
Have you seen another practitioner in regards to this accident? (circle) Yes / No
Type of Practitioner: (circle) Physiotherapist / Chiropractor / Medical Doctor
Name of Practitioner: _____ Date of Assessment: _____
Insurance Company: _____ Phone Number: _____
Name of Claim Worker: _____ Claim #: _____

Condition

Purpose of This Appointment: _____
Major Complaint: _____
Explain How/When Condition Occurred: _____
Condition has persisted for: ___ Days ___ Weeks ___ Months ___ Years
Symptoms: ___ Came on Suddenly ___ Came on Gradually ___ Come & Go

What Activities Make Condition Better?: _____

What Activities Make Condition Worse?: _____

Have you Ever Had This Condition Before?: No Yes When: _____

Other Doctors Seen For This Condition: _____

Describe Other Complaints Involving:

a) Neck/Head: _____

b) Mid Back/Shoulder/Arms: _____

c) Low Back/Hips/Legs: _____

Past Health History

Medical doctor's name: _____ Location: _____

Last Visit: _____ Purpose: _____

Previous Chiropractic Care: _____

Last Visit: _____

X-rays taken: _____ Where: _____ Date: _____

Surgeries: _____

Known Health Conditions: _____

Medications: _____

Childhood Diseases (please check if applicable)

<input type="checkbox"/> mumps	<input type="checkbox"/> eczema	<input type="checkbox"/> lumbago
<input type="checkbox"/> measles	<input type="checkbox"/> influenza	<input type="checkbox"/> diabetes
<input type="checkbox"/> chicken pox	<input type="checkbox"/> pneumonia	<input type="checkbox"/> asthma
<input type="checkbox"/> small pox	<input type="checkbox"/> tuberculosis	<input type="checkbox"/> anorexia nervosa

Past Conditions (please check any you have had)

<input type="checkbox"/> dizziness	<input type="checkbox"/> colds/flu
<input type="checkbox"/> fainting	<input type="checkbox"/> allergies
<input type="checkbox"/> headaches	<input type="checkbox"/> "growing pains"
<input type="checkbox"/> neck stiff or sore	<input type="checkbox"/> walking problems
<input type="checkbox"/> poor appetite	<input type="checkbox"/> digestive problems
<input type="checkbox"/> sinus congestion	<input type="checkbox"/> ear aches
<input type="checkbox"/> leg pain	<input type="checkbox"/> arm pain

Activities (please check those activities patient is involved in)

<input type="checkbox"/> hockey	<input type="checkbox"/> skiing	<input type="checkbox"/> swimming
<input type="checkbox"/> gymnastics	<input type="checkbox"/> skating	<input type="checkbox"/> running
<input type="checkbox"/> volleyball	<input type="checkbox"/> biking	<input type="checkbox"/> track & field
<input type="checkbox"/> basketball	<input type="checkbox"/> boating	<input type="checkbox"/> other _____

Habits

Quality of sleep: good fair poor
Does patient smoke?: no yes packs/day

Falls and Accidents

Please list all minor and serious falls or injuries this patient has experienced.
Keep in mind the above activities, motor vehicle accidents, slips, etc...

Family History

	diabetes	cancer	heart	back
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Siblings	_____	_____	_____	_____

I confirm that the information I have provided in regards to the current condition and past health history are true to the best of my knowledge.

Patient/Guardian Signature

Date

Name:
(please print)