Youth Health Profile

Date: ______________________________

Patient's Full Name:____

Patient's Date of Birth: __________________________ Sex: M F

Day/Month/Year (circle one)

Parent's Names:____

Full Address:

____

Street # Street Name Unit # City Province Postal code

Telephone (Parents):

Mother: ____

Primary: Please circle (home) (work) (cell) Secondary: Please circle (home) (work)(cell)

Father: ____

Primary: Please circle (home) (work) (cell) Secondary: Please circle (home) (work) (cell)

____

Email Address (Parents) Youth (for appointment reminders)

How did you hear about our clinic? ____

FOR OFFICE USE: -

Date	Presenting/Major Complaints
A	
B	

Health Profile:

1. Do you have any current symptoms or health concerns that brought you to our office? Please describe the most important one to you. (When it began, is it improving or getting worse, how it is impacting your life, any previous treatment)

   ____

   ____

2. Any other concerns that are impacting your life?

   ____

   ____

General Physical Stress/Trauma:

Primary Complaints and Pain Diagram:

Please mark an "X" on the line to indicate the severity of your condition:

Please mark any areas of concern on the diagrams below. N – numbness P- pins & needles B- burning A- aching S-stabbing Indicate any other problems as best you can.

Falls ____

Please provide the trauma/injury, level of trauma (mild/moderate/severe), dates, and any other important details of the following:

Falls ____

Sports injuries ____

Vehicle accidents ____

Other____

On a typical day I (check all that may apply):

□ Attend classes/school □ Computer/desk work

□ Extended video game/texting/TV □ Vigorous sport participation

Sports and Activity:

I am: □ very active □ active some days □ rarely active

I exercise/play sports: □ Daily □ Weekly □ Monthly □ Never

Type of exercise/sport/activity: ____

Have you experienced any injuries while participating in these sports/ activities? □ Yes □ No Describe:

____

Health/Illness/Trauma/Medical Treatment:

Current medical issues and the date of your last examination?

____

Have you ever been hospitalized or had surgery? □ Yes □ No

Reason: ____

Any major dental work or orthodontic work done? _______________________

Have you ever had physiotherapy? □ Yes □ No

Injury treated: ____

Do you consult with a Naturopathic Doctor? □ Yes □ No

Current care addressing: ____

Have you ever had chiropractic care in the past? □ Yes □ No

Reason: ______________________________

Chemical and Nutritional Stressors:

Are you taking any medications currently (prescription or over the counter)? □ Yes □ No Type and what for: ______________________________

Have you taken any in the past? Explain ______________________________

Please list any vitamins/herbs/supplements or natural remedies you take regularly: ______________________________

Do you drink coffee, specialty coffees, energy drinks or pop regularly?

□ Yes □ No Type and number/day ______________________________

Do you regularly consume diet drink beverages? □ Yes □ No #/day _____

Does your diet contain excessive amounts of refined sugar or refined carbohydrates (bread, pizza, candy, chocolate, pop, junk food)? □ Yes □ No

Do you consume fast food regularly? □ Yes □ No

Emotional and Mental Stressors:

With each of the following stressors please indicate the level of stress you have experienced (mild/moderate/severe) and details about the event.

Stress from an illness ______________________________

School stress ______________________________

Family stress ______________________________

Friend/Peer stress ______________________________

Past stress ______________________________

How would you grade your emotional/mental health?

□ Excellent □ Good □ Fair

and

□ Getting better □ Getting worse

Family History:

Circle any that apply to your parents, grandparents and or siblings and explain.

Diabetes ______________________ *High blood pressure* ______________________

Stroke ________________________ *Heart disease* ____________________________

Cancer _______________________ *Lung disease* ____________________________

Seizures ______________________ *Tremors* _________________________________

Neurological __________________ *Arthritis* _________________________________

Scoliosis _____________________ *ADD/ADHD*______________________________

Other ____

Your Specific Needs and Goals:

What are your objectives in consulting our office?

____

Is there anything else that may help us to understand you, your history, or your needs, which have not been discussed on this health profile?

____

____

Patient Name (print) __________________________________ **Date**_____________

Parent/Guardian signature ____

Please circle all the symptoms that you have experienced in the last 6 months and underline symptoms that have occurred in the past that were significant in your health history

HEAD:
Headache
Frequency __x/week or month
Back of head
Forehead
Temples
Migraine
Light bothers eyes
Blurred vision
Loss/change in vision
Loss/change in taste
Loss/change in hearing
Loss/change in balance
Dizziness
Light-headedness
Pain in ears or Ringing in ears

NECK:
Neck pain
Ache
Stiff
Sharp
Neck pain with movement
Grinding or popping sounds

MID-BACK:
Mid-back pain
Ache
Stiff
Sharp
Tension across shoulders
Pain between shoulder blades
Muscle spasms

CHEST:
Chest pain
Shortness of breath
Rib pain

HAND and ARM:
Pain in arm
RIGHT or LEFT
Tendonitis at elbow
RIGHT or LEFT
Pain into hands/fingers
RIGHT or LEFT
Pins and Needles sensation
RIGHT or LEFT
Numbness
RIGHT or LEFT
Hands cold
Loss of grip strength
Sore/swollen joints in fingers
Arthritis in fingers

LOW BACK:
Lower back pain
RIGHT or LEFT or *CENTRE*
Ache
Stiff
Sharp
Muscle Spasms
'Pinched nerve' sensation

Low back pain worse with:
Lifting
Stooping/bending
Standing
Sitting (chair or driving)
Lying down
Walking
Coughing

Low back pain better with:
Sitting
Standing
Bending
Lying down
Walking

LOWER BODY & LEG PAIN:
Pain into buttock – legs
RIGHT or LEFT
Pain into leg and foot
RIGHT or LEFT
Pins and needles in legs
Numbness in legs/feet
Pain into hips
RIGHT or LEFT
Swelling into legs or feet
Leg cramps
Foot pain
RIGHT or LEFT

DIGESTIVE/ABDOMEN:
Nausea
Bloating/Gas
Constipation
Diarrhea
Irritable bowels
Chron's
Food sensitivities

GENERAL HEALTH:
Nervousness
Anxious
Depressed feelings
Fatigue/Run down feeling
Trouble concentrating
Sleep challenges
Loss of weight __lbs
Gain of weight __lbs
Heart palpitations
Allergies ________________
Sensitivities ______________