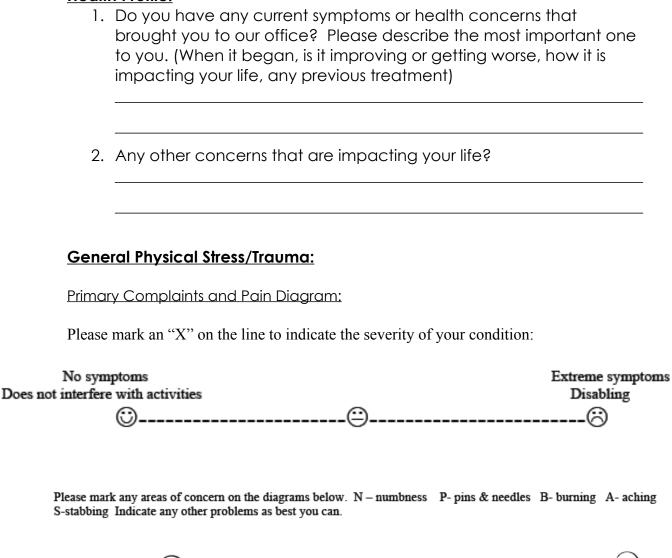
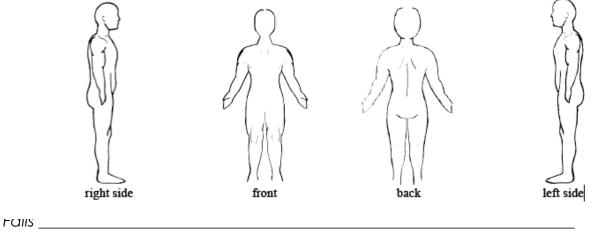
Youth Health Profile

Date:							
Patient's Full Name:							
Patient's Date of Birth:				Sex: M F (circle one)			
Parent's	Names:						
Full Addr	ess:						
Street #	Street Name	e Unit #	City	Province	Postal code		
Telephor	ne (Parents)	:					
		e circle (home) (work) (cell))	Secondary: Please circl	e (home) (work)(cell)		
Father: _ P	rimary: Please	circle (home) (work) (cell)		Secondary: Please circle	e (home) (work) (cell)		
Email Addr	Email Address (Parents) Youth (for appointment reminders)						
How did you hear about our clinic?							
FOR OFFIC	E USE:						
D	ate	Presenting/Major Complaints					
A							
В							

Health Profile:





Please p	provide	the trau	uma/injury	, level	of traum	na (I	mild/m	oderat	te/seve	re),
dates, a	and any	other in	mportant	details	of the fc	ollov	wing:			

Falls					
Sports injuries					
Vehicle accidents					
Other					
On a typical day I (check all that may apply):					
□ Extended video game/texting/TV □ Vigorous sport participation					
Sports and Activity:					
I am: □ very active	\Box active so	ome days	□ rarely a	ctive	
l 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? \Box Yes \Box No	

Reason: _____

Any major dental work or orthodontic work done?

Have you ever had physiotherapy? \Box Yes \Box No

Injury treated: _____

Do you consult with a Naturopathic Doctor? \Box Yes \Box No

Current care addressing: _____

Have you ever had chiropractic care in the past? \Box Yes \Box 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?

 \Box Excellent \Box Good \Box 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 <u>underline</u> 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 _____