# Youth Health History

Today's Date: _____ Birth Date: _____

Last Name: _____ First Name: _____

Parent/Guardian Names: _____

Address: _____ City _____ P.C. _____

Home Phone: _____ Parent Cell: _____ Work: _____

Care Card Number: _____ Family Physician: _____

Email address (for appointment reminders) _____

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

Primary reasons for consulting our office? _____

Have you had previous Chiropractic care? ❑ Yes ❑ No Dr.'s Name: _____

What other wellness professionals are currently a part of your health care team?

❑ Massage Therapist ❑ Naturopath ❑ Acupuncturist ❑ Homeopath ❑ Other _____

How many Medical Doctor's visits in the past year? ❑ None ❑ Less than 5 ❑ More than 5 ❑ More than 10

List previous surgeries and dates: _____

Medications (prescription and over-the-counter): _____

**Health History:**

Please check all of the following health concerns that you have experienced, even if you do not think that your answers relate to your present health concern.

| | | |
|---|---|---|
| ❑ Allergies | ❑ Digestive Problems | ❑ Neck Pain |
| ❑ Anxiety | ❑ Headaches | ❑ Numbness/Tingling |
| ❑ Asthma | ❑ Heartburn/Reflux | ❑ Sinus Trouble |
| ❑ Back Pain | ❑ Menstrual Cramps | ❑ Skin Conditions |
| ❑ Depression | ❑ Mood Swings | ❑ Other _____ |

**Stress History:**

| | | |
|---|---|---|
| ❑ Repeated/Prolonged Antibiotic Use | ❑ Car Accident | ❑ Major Illness |
| ❑ Fall/Jump from a Height | ❑ Head Trauma | ❑ Inhaler Use |
| ❑ Prescription Medications | ❑ Surgery | ❑ Contact Sports |
| ❑ Home Environment Stress | ❑ Vaccinations | ❑ Other Traumas (physical or emotional) |

please describe:_____

I hereby authorize Dr. Holdsworth and whoever may be designated as assistants to provide Chiropractic care as may be deemed necessary to my child/ward.

Signed: _____ (parent/guardian)