FULL SPECTRUM
CHIROPRACTIC PLLC

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Olympia WA 98502
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Adolescent Patient History

Patient Name: _____ Nickname:_____
Last First MI

Birthdate:____/_____/_____ Age:_____ SSN:_____ O Male O Female

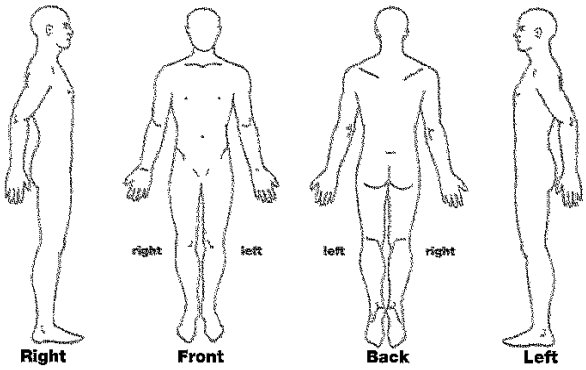
Mailing address:_____
City State Zip

Phone:_____ Cell:_____ Referred by:_____

Are you in pain? O Yes O No
Were you injured in school? O Yes O No
Were you injured playing sports? O Yes O No
If yes, what sports do you play? _____
Is this a new injury? O Yes O No
How long have you been in pain? _____

Please explain what happened:_____
_____
_____

Please circle any areas of pain or discomfort



Is it constant? O Yes O No Is it dull? O Yes O No
Is it sharp? O Yes O No Does it burn? O Yes O No

Is the pain getting worse? O Yes O No

Has this ever happened to you in the past? O Yes O No
If yes, explain:_____

Have you seen a medical doctor for this condition? O Yes O No
If yes, where?: _____

Have you ever been treated by a chiropractor before? O Yes O No
If yes, where?: _____

Are you on any medications? O Yes O No If so, which? _____

Have you ever had any of the following diseases or conditions? Please circle any you are experiencing currently.

O Neck pain	O Ear infections	O Heart murmur	O Digestive problems
O Back pain	O Chronic colds	O Heart defects	O Kidney problems
O Headache	O Asthma	O Anemia	O Bed wetting
O Arm pain	O Allergies	O Seizures	O ADHD
O Leg pain	O Sinus problems	O Cancer	O ADD

Please list any other conditions/diseases not listed above: _____
_____

Please list any serious accidents or surgeries with dates: _____
_____

Family health history: _____
_____

Signed: _____ Date: _____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this office and its doctors to administer care to my child as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Child's Name _____ Legal Guardian _____

Signed: _____ Date: _____

PARENT/GUARDIAN INFORMATION

Parent Name _____

DOB _____ ○ Male ○ Female

Address _____

_____

City State Zip

Cell Phone _____

Home Phone _____

Email _____

Status:
○ single ○ married ○ divorced ○ other _____

Employer _____

Address _____

_____

City State Zip

Parent Name _____

DOB _____ ○ Male ○ Female

Address _____

_____

City State Zip

Cell Phone _____

Home Phone _____

Email _____

Status:
○ single ○ married ○ divorced ○ other _____

Employer _____

Address _____

_____

City State Zip

INSURANCE INFORMATION

Company Name _____ Insured ID# _____
Include alpha prefix please

Insured's Name _____ Relation _____

Insured's DOB _____ Group # _____

I, _____ hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered to my child. I fully understand I am solely responsible for my child's balance not paid by my child's insurance company.

EMERGENCY CONTACT

Contact Name _____ Primary Phone _____

Relation to Patient _____ Secondary Phone _____

_____ _____

Signature **Date**