GREEN HILLS
Chiropractic Clinic

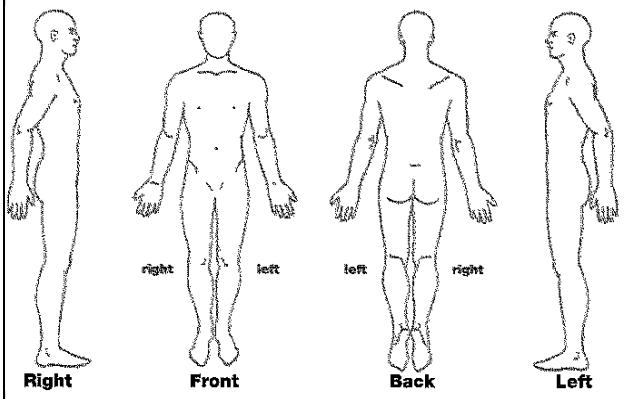
Adolescent Patient History

Patient Name: _____Nickname:_____
Last First MI
Birthdate:_____/_____/_____ Age:_____ SSN:_____ Male Female
Mailing Address:_____
City State Zip
Phone:_____ Referred by:_____

Are you in pain? Y N
Were you injured in school? Y N
Were you injured playing sports? Y N
If yes, what sports do you play? _____
Is this a new injury? Y N
How long have you been in pain? _____
Please explain what happened: _____
_____
Is the pain getting worse? Y N
Has this ever happened to you in the past? Y N
If yes, explain: _____
Have you seen a medical doctor for this condition? Y N
If yes, where?: _____
Have you ever been treated by a chiropractor before? Y N
If yes, where?: _____

Is it constant? Y N Is it dull? Y N
Is it sharp? Y N Does it burn? Y N

Please ***circle*** any areas of pain or discomfort



Are you on any medications? Y N If so, what? _____
Do you now or have you ever had any of the following diseases or conditions? (Circle all that apply)

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

Please list any other conditions/diseases not listed above: _____
_____
Please list any serious accidents or surgeries with dates: _____
_____
Family health history: _____
_____

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.
Insurance Company: _____ Policy #: _____
Signed: _____ Date: _____

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PARENT/GUARDIAN INFORMATION

Child's Name _____ **Date** _____ **Patient #** _____

Parent Name _____
DOB _____ Male Female
Address _____
_____
City State Zip
Cell phone _____
Home Phone _____
Email _____
Status: single married divorced other _____
Employer Information:
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 Information:
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. I fully understand I am solely responsible for my balance not paid by my insurance company.

EMERGENCY CONTACT

Contact Name _____ Primary Phone _____
Relation to Patient _____ Secondary Phone _____

Signature _____ **Date** _____