# Wellness for You NOW Chiropractic

**Dr. Joseph Manza, DC, CACCP**

**We are honored and blessed that you have chosen our office to serve your family.**
**Please know that we will care for your children with the greatest respect and tenderness.**

## ADOLESCENT HISTORY 13-17 YEARS OF AGE

Child's Name__________________________________________Birthdate________________ Sex: M F

Address____________________________________________City____________________Zip______________

Parent's Names___________________________________________________________________________

Parent's Phone____________________________________Work#___________________________________

Email___________________________________________________________________________________

Siblings and ages_________________________________________________________________________

Pediatrican__________________________________________________#____________________________

Whom may we thank for referring you to our office? _______________________________________________

**REASON FOR TODAY'S VISIT** _______________________________________________________________

Does your child complain of pain or discomfort? Yes No If yes, when did this occur? ______________________________

Was the onset: ____ Sudden ____ Gradual Is the problem: ____ Constant ____ Intermittent

Has your child ever had this problem before? Yes No ___________________________________________________

Has your child previously been treated for this problem? Yes No By whom? ____________________________________

**CHIROPRACTIC**

Has your child had their spine and nervous system checked by a chiropractor? Yes No

If yes, who was the chiropractor, when were they last seen, and what was the original reason for being checked?

_________________________________________________________________________________________

Were x-rays taken? Yes No If yes, when were they taken: ___________________________

**NUTRITION**

How would you rate your child's diet? Excellent Good Fair Poor

How many servings of fruits and vegetables per day? ___________

Does your child consume: ___ Sodas ___ Processed foods ___ High sugar foods (cereal/donuts)
___ Sweeteners ___ Fast food ___ Simple Carbs (bagels, white bread)

Other/explain: ___________________________________________________________________________

**TRAUMA**

Place of birth: ___ Home ___ Birthing Center ___ Hospital.
Provider: ___ Midwife ___ OB-Gyn. Other_____________________________________________
Type of Birth: ___ Vaginal ___ C-section
Was the birth: ___ Doctor assisted ___ Forceps
___ Vacuum Extraction ___ Twisting/Pulling Other______________________________________

Has your child had any recent falls or trauma? Yes No
Describe the trauma and the date it occurred: ______________________________________________________

_________________________________________________________________________________________

Has your child ever fallen down stairs or fallen from any height? Yes No If Yes:______________________________

Has your child ever been in a motor vehicle collision or near miss? Yes No If Yes:______________________________

Has your child had any other trauma or injuries? Yes No If Yes:_______________________________________________

Has your child ever had a bone fracture/dislocation Yes No If Yes:_______________________________________________

Has your child had any surgeries? Yes No If Yes:_______________________________________________

What sporting activities does your child engage in?

___ Soccer ___ Football ___ Gymnastics ___ Hockey ___ Lacrosse ___ Swimming/Diving
___ Dance ___ Wrestling ___ Baseball/Softball ___ Martial Arts ___ Basketball ___ Field Hockey

Other_______________________________________________________________________________________________

Has your child had any concussions? Yes No If yes, how many? ___________________________________________

Please briefly describe concussion history_______________________________________________________________

_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

Other than sitting in the classroom, does your child spend additional prolonged time sitting? Yes No

How much:________________________________

How would you rate your child's posture? Excellent Good Fair Poor

Please explain what you observe about their posture (slouch, forward head etc.): _____________________________________________

_____________________________________________________________________________________________________

On average, how many hours is your child in front of any screen? ___________________________________________

## Health History:

In order to better understand your child's level of health, please check any of the following body signals you have noticed your child currently or previously displaying.

___ Colic ___ Headaches ___ Digestive problems ___ Irregular Sleeping Patterns
___ Ear Infections ___ Seizures ___ Bed Wetting ___ Learning Disorders
___ Allergies ___ Tantrums ___ Chronic colds ___ Emotional Disorders
___ Asthma ___ Night Terrors ___ Chronic Infections ___ ADD/ADHD or Autism Spectrum

Other: ______________________________________________________________________________________

Does your child ever complain of back or neck pain? Yes No If Yes:_______________________________________________

Does your child ever complain arm/leg pain? Yes No If Yes:_______________________________________________

Are there any smokers in the child's home? Yes No Does your child smoke? Yes No

How many courses of antibiotics has your child been exposed to? ____________________________________________________

Is your child presently receiving any medications? Yes No If Yes:________________________________________

Has your child ever been to a hospital or ER? Yes No If Yes:________________________________________

**Quality of life and current health status:**

How do you grade your child's physical health? Excellent Good Fair Poor

How do you grade your child's emotional/mental health? Excellent Good Fair Poor

How do you grade your child's overall "quality of life"? Excellent Good Fair Poor

Do you believe your child is expressing their full health potential? Yes No If no, why? ___________________________

_____________________________________________________________________________________________________

How can we/chiropractic help your child achieve their optimum health? _____________________________________________

_____________________________________________________________________________________________________

Do you have any other concerns about your child's health? Yes No If Yes:________________________________________

_____________________________________________________________________________________________________

**Thank you for choosing Wellness for You NOW Chiropractic!**
**We know there is no more precious gift than the health and happiness of your child.**