YOUNG ADULT HISTORY FORM

Today's Date: _____

Name: _____ **Date of Birth:** _____
Last First

AGE: _____ **Grade In School:** _____ **Sex:** _____ **Home Phone:** (____)_____

Address: _____ **City/Town:** _____ **State:** _____ **Zip:** _____

Mother's Name: _____ **Phone:** (____)_____
Last First

Father's Name: _____ **Phone:** (____)_____
Last First

Referred by: _____

***HEALTH CONCERNS*:** Please list your / your child's top health concerns or complaints that you would like to address (in order of priority):

1) _____

2) _____

3) _____

Pregnancy History (Mother)
(If the child is adopted, answer to the best of your ability)
Did you experience any of the following during your pregnancy:

- ❑ Severe viral infection during the first trimester
- ❑ Breech position during pregnancy
- ❑ Accident or Infections
- ❑ Smoking
- ❑ Severe stress
- ❑ Pre-eclampsia
- ❑ C-section
- ❑ The child was a "blue baby"
- ❑ Alcohol consumption and/or drug use
- ❑ Radiation exposure
- ❑ Hypertension (high blood pressure)
- ❑ Toxoplasmosis
- ❑ Uncontrolled Diabetes
- ❑ Toxemia
- ❑ The child was premature (2+ weeks)

Comments: _____

_____

_____

Newborn History
Did the child experience any of the following as a newborn:

- ❑ Difficulty latching/sucking
- ❑ Breast fed – length of time _____
- ❑ Colic
- ❑ Formula fed
- ❑ Bottle fed

Health History
Has your child ever experienced the following or been diagnosed as having any of the following:

- ❑ Illnesses accompanied by a high fever
- ❑ Frequent headaches
- ❑ Seizures/Convulsions
- ❑ Chronic ear infections/earaches
- ❑ Head injury
- ❑ Serious fall(s) or repetitive falls
- ❑ Serious illness
- ❑ Epilepsy
- ❑ Meningitis
- ❑ Allergies to foods
- ❑ Environmental allergies
- ❑ Chemical insensitivities
- ❑ Undergone any surgeries
- ❑ Neck or back problems
- ❑ Dizziness
- ❑ Diabetes
- ❑ Hypoglycemia (low blood sugar)
- ❑ Trouble with bladder control (enuresis)
- ❑ Fainting
- ❑ High blood pressure
- ❑ Heart disease
- ❑ Asthma
- ❑ Sinus problems
- ❑ Constipation
- ❑ Diarrhea
- ❑ Digestive disorders
- ❑ Rheumatic Fever
- ❑ Joint or muscle problems
- ❑ Adverse reaction to any vaccinations (even if mild)

If yes, please explain: _____

_____

Developmental History
Does or did your child have any of the following:

- ❑ Difficulty with crawling (on all fours)
- ❑ Difficulty learning to ride a bike
- ❑ Difficulty learning to read
- ❑ Difficulty using utensils
- ❑ Difficulty tying shoes
- ❑ Poor hand-eye coordination
- ❑ Did not crawl on all fours
- ❑ Appeared clumsy
- ❑ Difficulty with writing
- ❑ Difficulty buttoning clothing
- ❑ Difficulty or awkward with walking/running
- ❑ Difficulty sitting still or paying attention

At what age did your child start to walk unassisted: _____

Comments:_____

_____

Neurological/Other
Has your child ever been diagnosed by a medical professional with any of the following, if yes, by whom:

- ❑ Hearing loss or impairment
- ❑ Neurological disorders
- ❑ Obsessive Compulsive Disorder (OCD)
- ❑ ADD/ADHD
- ❑ Dyslexia
- ❑ Visual impairment
- ❑ Anxiety/Depression
- ❑ Autism/Autism Spectrum Disorder
- ❑ Tourette's Syndrome
- ❑ Other_____

GENERAL INFORMATION:

Height:_____ Weight:_____ Recent Weight Loss ☐ / Gain ☐ Amount: _____ lbs

Reason / method for weight loss / gain: _____ Number of Bowel Movements per day _____

Difficulty falling asleep? ☐ Y ☐ N Difficulty staying asleep? ☐ Y ☐ N Tired after full night's sleep? ☐ Y ☐ N

Lightheaded / irritable when hungry? ☐ Y ☐ N Crave sugar / salt? ☐ Y ☐ N Fatigue after meals? ☐ Y ☐ N

Need coffee/sweets 3-5pm? ☐ Y ☐ N Does your child eat Breakfast? ☐ Y ☐ N Or eat snacks? ☐ Y ☐ N

Usual Breakfast time? _____ Usual breakfast foods:_____

Usual Lunch time? _____ Usual lunch foods:_____

Usual Dinner time? _____ Usual dinner foods:_____

Are there usual Snack times? _____ Usual snacks:_____

List the three healthiest foods eaten during the average week: _____ _____ _____

List the three worst foods eaten during the average week: _____ _____ _____

Are there any dietary restrictions? ☐ Y ☐ N Please explain: (vegetarian, gluten / dairy intolerance, Kosher etc.)_____

_____

HEALTH & FAMILY HISTORY:

Mark an X for any conditions that **you**, or any of **your family members** have now or have had in the past:

	Self	Mother	Father	Sibling(s)	Paternal Grandparent	Maternal Grandparent
Alcoholism						
Anemia						
Cancer						
Cold sores						
Deep vein thrombosis						
Depression/Anxiety						
Diabetes						
Eczema/Psoriasis						
Epilepsy						
Goiter						
Gout						
Heart disease						
Hepatitis A/B/C						
Herpes						
High Blood Pressure						
HIV/AIDS						
Pleurisy						
Pneumonia						
Stroke						
Tumor(s)						
Ulcer(s)						
Other:						

NATIONALITY: Some health issues can be related to our familial nationality or heritage. Please list your family heritage below:

Mother's Family _____ Father's Family_____

ALLERGIES / SENSITIVITIES: Please check and list all allergies / sensitivities

☐ **Food:** ☐Gluten ☐Dairy ☐Soy ☐Nuts ☐Other _____

☐ **Medications:** _____

☐ **Seasonal/Latex/Other:** _____

ACCIDENTS: Has your child been involved in any of the following types of accidents? (check all that apply)

☐ Automobile ☐ Motorcycle ☐ Bicycle ☐ Sports ☐ Playground ☐ Abuse ☐ Other

Year ***(approximate)***	**Please describe** ***(injuries, treatment, outcome)***

INJURIES: Has your child ever injured any of the following regions? (check all that apply)

☐ Head ☐ Neck ☐ Rib/Chest ☐ Back ☐ Pelvis/Hip ☐ Arm/Hand ☐ Leg/Foot

Year ***(approximate)***	**Please describe** ***(injuries, treatment, outcome)***

SERIOUS ILLNESSES / HOSPITALIZATIONS / SURGERIES: Please detail hospitalizations / serious illnesses / surgeries

Year ***(approximate)***	**Reason**	**Outcome**

MEDICATIONS: Please list all medications your child is currently or has taken (prescribed or over-the-counter)

Medication Name	**Condition**	**Date Started**	**Prescribed By?**

NUTRITIONAL SUPPLEMENTS: Please list all Vitamins and Nutritional Supplements your child is currently or has taken

Supplement	**Brand** & **Amount Consumed**	**Date Started**	**Prescribed by?** *(if applicable)*

PREVIOUS MEDICATION HISTORY: Please list an approximate number of times your child has taken antibiotics for illnesses, ear infections, skin disorders (including acne), dental procedures, surgery etc._____ Has your child ever been on a long term antibiotic (1 month or more) or Intravenous (IV) ? ☐Y ☐N Has your child ever taken probiotics? ☐Y ☐N

HABITS: Please include current and previous amounts

	Daily	Weekly	Monthly	Never	Amount
Soda/Diet Soda	☐	☐	☐	☐	_____
Coffee/Caffeine	☐	☐	☐	☐	_____
Alcohol	☐	☐	☐	☐	_____
Tobacco	☐	☐	☐	☐	_____
Rec. Drugs	☐	☐	☐	☐	_____

If your child no longer consumse the above, please note length of consumption and date stopped.

	5-7x/wk	3-5x/wk	1-3x/wk	None	
Exercise/Sports	☐	☐	☐	☐	
	8+ hrs	**7-8 hrs**	**6-7 hrs**	**5-6 hrs**	**<5 hrs**
Sleep	☐	☐	☐	☐	☐
	5+	**4**	**3**	**2**	**1**
Meals / day	☐	☐	☐	☐	☐
	8+ cups	**4-7 cups**	**2-4 cups**	**<8 oz**	
Water / day	☐	☐	☐	☐	

How many times a week does your child eat out?: _____

How many times a week does your child eat fish? _____

How many times a week does your child eat raw nuts or seeds?: _____

Has your child lived or traveled outside of the United States? ☐ Y ☐ N If yes: Where _____

_____

Do you / your child have any pets or farm animals? ☐ Y ☐ N If yes: _____

STRESS LEVEL: ☐ Very High ☐ High ☐ Medium ☐ Low

If you have any concerns or questions you would like to note here, or issues you think might be related to your child's condition please do not hesitate to discuss any matter with Dr. Slavin at any time.

_____

_____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. Jacqui Slavin, D.C. of Functional Wellness, LLC to examine, evaluate and treat _____ under the scope of Chiropractic Care in the

Name of Minor Patient

State of Colorado.

_____ _____

Signature and relation of person completing this form **Date**