Dr Michael Beattie, DC
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Introduction and History for those age 6-18

Date: ____

Name:	Date of birth (Month/Day/Year):
Home Address and Phone Number:	E-Mail:
Family Medical Doctor:	Referred by (please include person's name): ☐ Friend/Family ☐ M.D. / D.C. ☐ Internet/Add
Have you had Chiropractic care before? If so, when and by whom?	Hobbies and Sports you enjoy:
Parent's Names:	Please circle sex: Male Female

Why this form is important:

Our office focuses on your ability to be healthy. Our goals are to **first** address the issues that brought you to this office, and **second**, offer the **opportunity to improve your health potential in the future**. In order to give you the best possible Chiropractic care, we will need to discover any '***stresses'*** that are placed on your body. Please take the time to fill out this form completely, as each question gives us a clearer picture of your current health status.

Reason for consulting this office

❑ **Wellness / Prevention Care** - *I wish to continue my Chiropractic Wellness Care*. Just answer the following questions that apply.

❑ Please describe your current problem, including the effect it has had on your life:

____

____

____

____

Please describe the character of your pain (check all that apply)

❑ Sharp/Stabbing ❑ Sharp/Dull ❑ Achy ❑ Dull ❑ Soreness ❑ Weakness
❑ Throbbing/Gnawing ❑ Numbness ❑ Shooting ❑ Gripping/Constricting
❑ Burning ❑ Tingling ❑ Other: ______________________________

PLEASE TURN OVER →

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Your name: ___________________________________

How often are the complaints present?
❑ Constant (76-100%) ❑ Frequent (51-75%) ❑ Occasional (26-50%) ❑ Intermittent (25% or less)

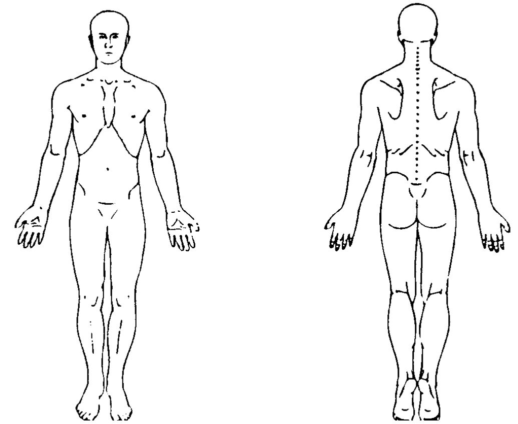
When is the pain or symptoms worse:
❑ When you wake up ❑ During the day ❑ After work ❑ In the evening ❑ After eating
❑ While sleeping

How bad is your pain or ache? Please circle a number (0= no pain, 10 = unbearable pain)
0 1 2 3 4 5 6 7 8 9 10

Since your problem began is the pain : ❑ increasing ❑ decreasing ❑ not changing

When did your problem begin: ______________________ (specific date if possible)

Please draw on the diagram where you feel your symptoms: →



Do you sleep on your:
❑ Back ❑ Stomach ❑ Left Side ❑ Right Side

General physical activity:
❑ No regular exercise program
❑ Light exercise program ❑ Moderate exercise program
❑ Strenuous exercise program

How would you rate your stress level:
❑ No Stress ❑ Minimal Stress
❑ Moderate Stress ❑ Greatly Stressed

Who else have you seen for this condition: ____

____

Please describe any falls, auto accidents or major injuries (include Month/Year, Type of accident):

____

Please describe any and all past surgery: ____
____

Please list ANY and ALL medication (prescription and over the counter): that you are currently taking: _______

____

Please Circle Any That Apply: PERSONAL HISTORY: Aneurysm, Osteoporosis, Diabetes, Thyroid Disease, Arthritis, Cancer, Stroke, Heart Condition, Hypertension, Asthma, Psoriasis. Other: _______________
____

Please Circle Any That Apply: FAMILY: Aneurysm, Osteoporosis, Diabetes, Thyroid Disease, Arthritis, Cancer, Stroke, Heart Condition, Hypertension, Polio, Asthma, Psoriasis. Other:_________________
____

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Please check all symptoms or areas where you have problems, even if they do not seem related to your current problem.

- ❑ Headaches/Migraines
- ❑ Dizziness
- ❑ Eyes/Vision
- ❑ Concentration Loss
- ❑ Depression
- ❑ Nervousness
- ❑ Sleeping
- ❑ Loss Energy
- ❑ Tired Mornings
- ❑ Loss of Taste/Smell
- ❑ Buzzing/Ringing in Ears
- ❑ Fatigue
- ❑ Fainting
- ❑ Sinus
- ❑ Neck Pain/Stiffness
- ❑ Shoulder
- ❑ Upper Back
- ❑ Mid Back
- ❑ Chest Pain
- ❑ Menstrual Pain/Irregularity
- ❑ Lungs
- ❑ Heart
- ❑ Stomach
- ❑ Indigestion
- ❑ Bladder
- ❑ Liver
- ❑ Colon
- ❑ Kidney
- ❑ Constipation
- ❑ Urination
- ❑ Low Back Pain
- ❑ Hip Pain
- ❑ Leg Pain/Cramps
- ❑ Poor Circulation
- ❑ Numb Feeling
- ❑ Feeling of Pins/Needles
- ❑ Hot Flashes
- ❑ Cold Sweats
- ❑ Diarrhea
- ❑ Fever

- Do you drink bottled or filtered water: Yes No
- How much water do you drink in a day: ________________
- How many servings of fruit and vegetables do you enjoy on a typical day: _______________

If you remember the details, what was your birth delivery like (eg – breach, c section, long): ___________

____

Have you had any or all of your childhood vaccinations? ❑ All ❑ Some: _______________________

Any reactions to vaccinations? ____

Please list all supplements and vitamins you take: ____

____

How many hours a day do you spend in front of:

______ Computer ______tv ______ gaming

How many hours a day do you exercise: ____________

How would your rate your health:

Yuk I've never felt worse — Wow I feel great!

1 2 3 4 5 6 7 8 9 10

What is your goal or expectations with Chiropractic care: _____________________________________

____

____

Health is significant, but not necessarily serious
– we will do what we can to make each visit stress-free.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Care and Nutritional Care, and I give authority for these procedures to be performed. I have been informed of the Clinic's financial policy and agree that I am responsible for all bills incurred at this office. I have had an opportunity to review the privacy policy and agree to its terms.

Patient/Guardian Name: _______________________

Patient/Guardian Signature ______________________________ Date: ________________________