YOUTH **HISTORY FORM**

INTERNAL USE ONLY

// COMPLETE: *Patient Information*

Patient Name ______________________ Date ____________

Address ______________ City ____________ State ______ Zip ________

Drivers License # ______________ SSN #: ____________ DOB: ________

Phone ____________ Email Address ______________ Sex ☐ F ☐ M

Occupation ______________ Employer ______________

Emergency Contact Name ______________ Phone: ____________

Relationship to Patient ______________ Alt Phone ____________

// REFERRAL: *How did you find us?*

☐ Friend / Family Member If so, what is their name? ______________

☐ Healthcare Provider If so, what is the practice name? ______________

☐ Walk-In Patient ☐ Online Search ☐ Social Media ☐ Other

// COMPLETE: *Insurance Information*

Insurance Company ______________ Relationship to Insured ______________

POLICY HOLDER INFORMATION

Name ______________ DOB ____________ SSN ____________

Occupation ______________ Employer ______________

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// COMPLETE: Youth History *(Age 25 months - 13 years)*

Age ______________ yrs. / mo. Weight ______________ lbs. / oz. Height ______________ ft. / in.

What school or daycare does your child attend? What grade? ____________________

Family Doctor / Pediatrician: ____________________ Date of last visit ____/____/____

Reason for last visit: ____________________

// COMPLETE: Reason for Your Child's Visit Today *(check all that apply)*

- ☐ Headaches
- ☐ Balance Issues
- ☐ Poor Memory/Concentration
- ☐ Mood/Anxiety
- ☐ Head Injury
- ☐ Vertigo/Dizziness
- ☐ Sleep/Fatigue
- ☐ Nutritional Counseling
- ☐ Other ____________________

☐ If injury occurred, when? ____/____/____ ☐ Date symptoms started ____/____/____

☐ Another type of accident, trauma, or injury

Please explain what the incident was.Was it at school, home, or somewhere else?

____

☐ Has your child had any surgeries? ☐ No ☐ Yes. If yes, for what? ____________________

____

// Medications? *List all your child is currently taking.*

1. ______ 2. ______ 3. ______ 4. ______
5. ______ 6. ______ 7. ______ 8. ______

// Over the Counter Meds / Vitamins? *List all your child is currently taking.*

1. ______ 2. ______ 3. ______ 4. ______
5. ______ 6. ______ 7. ______ 8. ______

// Does your child have any known food, drug or environmental allergies?

1. ______ 2. ______ 3. ______ 4. ______
5. ______ 6. ______ 7. ______ 8. ______

// Overall Health & Activity *Please answer the following questions.*

Please describe your child's hobbies and involvement in sports.

____

____

____

____

How much excercise does your child get? *Please circle hours per day.*

1 2 3 4 5 6 7 8 9 10

How much time does your child spend on the computer or watching TV? *Please circle hours per day.*

1 2 3 4 5 6 7 8 9 10

Rate your child's ability to focus during school (if applicable) *Please circle 1 (low) to 10 (high).*

1 2 3 4 5 6 7 8 9 10

Please rate the stress level in your home. *Please circle 1 (low) to 10 (high).*

1 2 3 4 5 6 7 8 9 10

What is the beverage your child drinks the most? _______________________________

Briefly describe your child's diet *(how many meals, snacks, types of food, etc.):*

____

____

____

____

// AUTHORIZATION FOR CARE OF MINOR *Please sign below.*

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 the payment of all fees charged by this office.

GUARDIAN NAME: _______________________________ **DATE:** ____/____/____

GUARDIAN SIGNATURE: _______________________________