TEEN/PRE-TEEN HEALTH QUESTIONNAIRE

CLEVELAND CHIROPRACTIC ASSOCIATES, INC.

Name: _____ Date:_____

Male/Female

Age: _____

Purpose of this appointment and list your complaints:_____

_____

_____

1) Have you ever received Chiropractic care before? If so, when? What age?

_____

2) Do you participate in Sports, Activities, or Extra Curricular Programs?

_____

3) Do you exercise regularly? If so how many times per week?

_____

4) If you work out what equipment is used? Weights, Machines, etc.

_____

5) Have you been diagnosed with any of the following: ADD/ADHD, Asthma, Autism, Cerebral Palsy, Diabetes, or Auto Immune Diseases?

_____

6) Do you take any medication(s)? If so, what is it for?

_____

7) Do you take any vitamins or supplements? Please list.

_____

8) Have you started your menstrual cycle, if so at what age? _____

9) Are you on any medications or supplements? If so please list them and what they are used for.

_____

_____

_____

10) Have you had any surgeries, hospitalizations, or injuries? If so please explain.

_____

_____

_____

11) Is there any additional information that you would like us to know?

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