

**R. Tyler Given, D.C.**  
Family Chiropractor

**Teen New Patient Information**

Teen's Name \_\_\_\_\_ Nickname or Preferred Name \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell/Other Phone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Parent's Names \_\_\_\_\_

Referred by \_\_\_\_\_ E-Mail \_\_\_\_\_

**Health Information**

Purpose of this visit

I have no symptoms. I would like my spine checked.

Symptoms (describe) \_\_\_\_\_

Other doctors seen for this condition \_\_\_\_\_

Have you been treated for any health condition during the past year?  Yes  No

Describe \_\_\_\_\_ Date of last physical exam \_\_\_\_\_

List any medications or drugs you take \_\_\_\_\_

List any surgeries you have had \_\_\_\_\_

List any serious illnesses you have had \_\_\_\_\_

List any serious falls or accidents \_\_\_\_\_

**Labor and Delivery Information** (if known)

Length of labor and delivery \_\_\_\_\_ Were forceps used? Yes No Vacuum extractor? Yes No

C-section? Yes No Breech delivery? Yes No Birth injuries? Yes No

Any newborn problems? Yes No If yes, describe \_\_\_\_\_

**Check any symptoms or problems you have had or are having**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Spinal Curvature                    | <input type="checkbox"/> Allergies/Asthma              | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> Headaches                           | <input type="checkbox"/> Ear infections                | <input type="checkbox"/> Respiratory infections |
| <input type="checkbox"/> Neck pain or stiffness              | <input type="checkbox"/> Poor immune response          | <input type="checkbox"/> Skin problems          |
| <input type="checkbox"/> Upper or mid back pain or stiffness | <input type="checkbox"/> Sinus problems                | <input type="checkbox"/> Heart problems         |
| <input type="checkbox"/> Arm pain or numbness                | <input type="checkbox"/> Learning disorders            | <input type="checkbox"/> Poor posture           |
| <input type="checkbox"/> Low back pain or stiffness          | <input type="checkbox"/> Bed wetting                   | <input type="checkbox"/> Growing pains          |
| <input type="checkbox"/> Leg pain or numbness                | <input type="checkbox"/> Stomach or digestive problems | <input type="checkbox"/> Other _____            |

Additional information \_\_\_\_\_

**Payment is expected at the time services are provided**

Do you have chiropractic insurance benefits?  Yes  No  Don't Know

I understand and agree that I am personally responsible for professional services rendered to my teen.  
If insurance is involved, I authorize Dr. Given to release any information needed to process my claim.

Teen's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian's Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_

Information Taken By \_\_\_\_\_ Date \_\_\_\_\_