About the Child

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____

Cell Phone (_____) _____

Birthdate _____ Age _____

Gender ❒M ❒F

Parent's Name _____

Parent's Employer _____

Parent's Work Phone _____

Parent's Email Address _____

Who referred you to our office? _____

Credit Card number to be put on file for outstanding balances. This card WILL NOT be charged before informing you first.

Credit Card# _____

Exp: _____

Child's Routine

Play video games daily? ❒ Yes ❒ No

If yes, ❒ Less than 1 hour ❒ 1-2 hours ❒ 3-5 hours

Drink soda daily? ❒ Yes ❒ No

If yes, ❒ 1-2 soda's ❒ 2-4 soda's ❒ 4-6 soda's

Drink energy drinks daily? ❒ Yes ❒ No

If yes, ❒ 1-2 drinks ❒ 2-4 drinks ❒ More than 4

Eat fast food? ❒ Yes ❒ No

If yes, ❒ 1 time a week ❒ 2 times a week

❒ More than 3 times a week

Exercise? ❒ Yes ❒ No

If yes, ❒ 1-2 times a week ❒ 2 times a week

❒ More than 3 times a week

How many hours sleep per night?

❒ Less than 6 ❒ 6 ❒ 7 ❒ 8 ❒ More than 8

Reason For This Visit

Describe the purpose of this visit: _____

_____

_____

Is the purpose of this appointment related to:

❒ Sports ❒ Auto ❒ Fall

❒ Chronic Discomfort ❒ Home Injury ❒ Other

Please Explain: _____

_____

When did this condition begin? _____

Has this condition

❒ gotten worse ❒ stayed constant ❒ comes and goes

Does this condition interfere with

❒ sleep ❒ daily routine ❒ other activities

Please Explain _____

Has this condition occurred before? ❒ Yes ❒ No

Explain _____

Have you seen other doctors for this condition?

❒ Yes ❒ No

Dr.'s Name (s) _____

Type of treatment _____

Results _____

Child's Health History

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and course of care for your child.

❒ Vision Problems
❒ Pink Eye
❒ Headaches
❒ Ear Problems
❒ Sleeping Disorders
❒ Tubes in the Ears
❒ Irritability
❒ Attention Problems
❒ Skin Problems
❒ Frequent Colds
❒ Breathing Problems
❒ Colic
❒ Allergies
❒ Digestive Problems
❒ Asthma
❒ Other _____
❒ Hyperactivity
❒ Constipation
❒ Bed Wetting

Goals For My Child's Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning in their bodies - wellness care. Your doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

❒ **Relief Care:** Symptomatic relief of pain or discomfort

❒ **Corrective Care:** Correcting and relieving the cause of the problem as well as the symptoms.

❒ **Wellness Care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

❒ I want the doctor to select the type of care appropriate for my condition.

_____

Parent/Guardian Signature Date

Child's Current Health Status

Is your child accident Prone? ❒ Yes ❒ No

Has your child:

.....been hospitalized? ❒ Yes ❒ No

.....had a severe fall? ❒ Yes ❒ No

.....been in a car accident? ❒ Yes ❒ No

Has your child ever taken antibiotics? ❒ Yes ❒ No

If "Yes", explain _____

Is your child currently taking any medication?

❒ Yes ❒ No

If "Yes", explain _____

Does your child have difficulty interacting with schoolmates or friends? ❒ Yes ❒ No

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?

❒ Yes ❒ No

What changes (if any) in your child's health or behavior would you like accomplished? _____

_____

Vaccinations

Have you chosen to vaccinate your child?

❒ Yes ❒ No

If "Yes", check all vaccinations the child has received.

❒ DPT ❒ MMR ❒ Polio

❒ Chicken Pox ❒ Hepatitis ❒ Other _____

_____

Describe any and all reactions to vaccine(s).

_____

_____

Emergency Contact

Name _____

Relationship _____

Work Phone _____

Home Phone _____

Cell Phone _____

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my child's condition through the use of adjustments to the spine, as he or she deems appropriate. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if my child's care is suspended or terminated, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

Patient Name (print) Date Guardian or Spouse/s Signature Date

Who should receive bills for payment on account?

☐ Parent ☐ Personal Health Insurance ☐ Auto Insurance

Ownership of X-Ray Films

It is understood and agreed that the payments to the Doctor for X-Rays is for examination of X-Rays only. The X-Ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

My Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and policy holder. I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. I hereby authorize assignment of insurance rights and benefits (if applicable) directly to the provider for services rendered to my child.

Patient name:_____

Signature:_____ Date:_____