

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: _____