

ABOUT THE CHILD

Name _____
 Address _____
 City _____ State _____ Zip _____
 Home phone _____ Birth date _____
 Age _____ Gender _____ Weight _____

ABOUT THE PARENT

Name _____
 Employer _____
 Work address _____
 Work phone _____
 Type of work _____
 Marital Status _____
 Social Security # _____
 Driver's License # _____
 E-mail address _____
 Payment Method for First Visit Cash Check Credit card

VACCINATIONS

Have you chosen to vaccinate your child? Yes No
 If yes, check all that your child has received.
 DPT MMR Chicken Pox Hepatitis Other
 Describe any and all reactions to vaccine(s).

REASON FOR THIS VISIT

Current Health Complaints/Reasons for consulting our office.
 1. _____
 2. _____
 3. _____
 4. _____

Is the purpose of this appointment related to
 Sports Auto Fall Home Injury
 Chronic Discomfort 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

Please explain _____

Have you seen other doctors for this condition?
 Yes No

Doctor's Name(s) _____

Type of treatment _____

Results _____

AWARENESS OF CHIROPRACTIC PRINCIPLES

| Were you aware that | Yes | No |
|---|--------------------------|--------------------------|
| • Doctors of Chiropractic work with the nervous system? | <input type="checkbox"/> | <input type="checkbox"/> |
| • The nervous system controls all bodily functions and systems? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Chiropractic is the largest natural healing profession in the world? | <input type="checkbox"/> | <input type="checkbox"/> |
| • If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? | <input type="checkbox"/> | <input type="checkbox"/> |

EXPERIENCE WITH CHIROPRACTIC

Who can we thank for referring you to this office? _____

Have you personally been adjusted by a Chiropractor before? Yes No _____

Reason for those visits? _____

Doctor's name _____ Approximate date of last visit _____

Has your child been adjusted by a Chiropractor? Yes No Approximate date of last visit _____

Has any adult in your family seen a Chiropractor? Yes No

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, care plan and the possibility of being accepted for care.

- | | |
|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Attention problems | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Sleeping disorders |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Tubes in the ears |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Ear problems | <input type="checkbox"/> Other _____ |

CHILD'S CURRENT HEALTH STATUS

| | No | Yes | If Yes, please explain |
|--|--------------------------|--------------------------|------------------------|
| Has your child ever: | | | |
| ...taken antibiotics? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| ...been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| ...had a severe fall? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| ...been in a car accident? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Is your child | | | |
| ...accident prone? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| ...currently taking any medication(s)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| ...having difficulty interacting with others? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior? | | | |
| _____ | | | |
| What changes (if any) in your child's health or behavior would you like accomplished? | | | |
| _____ | | | |

AUTHORIZATION TO CARE FOR A MINOR CHILD

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desire for your child(ren) when recommending his/her 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
- Comprehensive 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 or legal guardian's name (print)

Patient's name (print)

Parent/Guardian's signature

Date

Witness' signature