

PATIENT INFORMATION *all fields required*

Print Full Name: _____ Name you go by: _____ Date: _____
Parent / Guardian's Names: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Age: _____ Birth Date: _____ Sex: Male Female Number of siblings _____
Most of our patients are referred to our office by a caring family member or friend. How did you hear about our office or who referred you? _____

PHONE NUMBERS

Home: _____ Parent's Work: _____ ext. _____ Cell: _____
Preferred phone number: Home Work Cell Best time to reach you: _____
In case of emergency, notify: _____ Relationship: _____ Phone: _____
Parent / Guardian Email Address: _____

HEALTH HISTORY

Chiropractic care is for optimal health and pediatric development.

Is the purpose of this visit: Wellness Check-up Injury / Accident Other

Please Explain: _____

If your child is experiencing Pain / Discomfort, please identify where and for how long: _____

- Spinal misalignments can put pressure on nerves for long periods of time. How long have you had the above problems? (If accident or injury, write date) _____
- Have you ever had this problem before? Yes No Have you seen other doctors for this problem? Yes No
- Nerve pressure & Irritation can be constant or occasional. How often do you have the above problems?
 It is constant OR On and off during the day OR It comes and goes throughout the week
- How is the problem now? Rapidly improving Improving slowly About the same Gradually worsening
- Irritation to different nerve fibers can create different sensations. Is yours: sharp dull throbbing
 burning numb achy tingling radiating?
- Rate your current pain intensity from 0 to 10 with 10 being the worst pain: 0 1 2 3 4 5 6 7 8 9 10
- Spinal misalignments can cause weakening of the entire spine. Is yours worse in the morning, evening, or after a specific activity? _____
- What makes your condition better? _____
- Poor posture leads to poor health, and often indicates spinal problems.
How would you rate your posture: Poor Good Excellent

MEDICATIONS & SURGERY

Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications or OTC drugs are you currently taking? _____

Many people with spinal problems experience health crisis before seeking chiropractic care. Have you had any major hospitalizations or surgeries that the doctor should know about? Yes No If YES, please explain:

PRENATAL HISTORY

List any complications during pregnancy: _____

Complications during delivery: _____

Medications during pregnancy / delivery: _____

Birth Intervention: Forceps Vacuum Extraction Caesarian Section

The vast majority of our patients have experienced dozens of falls or impacts (auto/school/sports/hobby related) that could cause spinal misalignments. Help us discover a few of yours.

- Which of the following sports have you been involved in? Football Ski / Snowboard Soccer Running Gymnastics/Cheerleading Martial Arts Horseback riding Other; _____
- Have you ever... Fallen down the stairs Slipped/Fell on the ground (or ice) Had a sports injury Broken a bone if so, which one? _____
- Have you been involved in any automobile accidents or minor fender benders? Yes No Date: _____
- Any traumas not listed above: _____

Name of Family Doctor / Pediatrician? _____

Have you ever been seen on an emergency basis? Yes No Reason / Date: _____

Exercise: None 1-3x week 4-7x week Gym Sports Other: _____

PAST HISTORY

Have you ever been diagnosed with any of the following conditions? Please check all that apply:

- Broken bone Dislocations Tumors Rheumatoid Arthritis Fracture Disability Cancer Allergies
- Heart Attack Osteoarthritis Diabetes Cerebral Vascular Asthma Fatigue Digestive Problems
- Sciatica Genetic Disease Other _____

CHIROPRACTIC HISTORY

Research shows that your spine should be checked regularly. When did you last see a chiropractor? _____

Reason for care: _____ Favorable outcomes? Yes / No Did you follow recommendations? Yes / No

Who else in your family is under chiropractic care? _____

ACKNOWLEDGMENTS

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

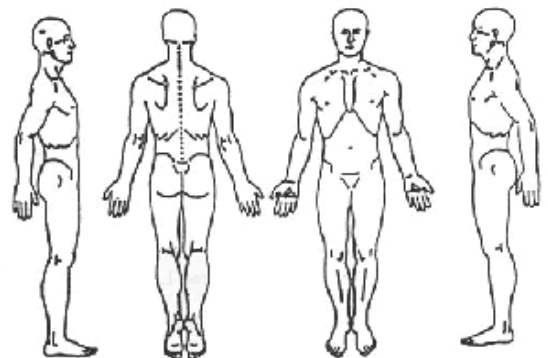
I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, text messages, or health information to me as an extension of my care in this office.

I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Please place an "X" on the diagram to the right where you have any pain, numbness, tingling, or other problems.



Patient / Guardian Signature Date

Doctor Signature Date