TRAVEL CARD

Patient # _____________ Phone # __________________ Cell # ____________________ Work #_______________________

Name (Last, First, MI) ____ E-mail ______________________________

Address ____

City/State/Zip ____

DOB ________/________/________ Age ______________ Sex: M F Height: ____________ Weight: _______________

Employer: ____ Type of Work: _____________________________________

SS # ____________________________ Spouse _____________________________________ # of Children ___________

Names/Ages of Children ____

Referred to This Office By: _________________________________ Relation To Patient ___________________________

Primary Ins. _____________________________________ Secondary Ins. _______________________________________

PEDIATRIC PATIENT INTRODUCTION

PURPOSE OF THIS APPOINTMENT: ____

WHAT IS THIS KEEPING YOUR CHILD FROM DOING:

PLAYING _____ PLAYING OUTSIDE _____ SPORTS/HOBBIES _____ SLEEPING _____ GOOD HOME LIFE _____

SCHOOLWORK _____ CONCENTRATING _____ OTHER ______________________________________

NO. OF HOURS SLEEP PER NIGHT: _______ QUALITY OF SLEEP: GOOD _____ FAIR _____ POOR _____

TYPE OF BIRTH: NORMAL VAGINAL ______ FORCEPS ______ BREECH ______ CESAREAN ______

HOME ______ BIRTHING CENTER ______ HOSPITAL ______

PROBLEMS DURING PREGNANCY: ____

PROBLEMS DURING LABOR/DELIVERY: ____

CONGENITAL ANOMALIES/DEFECTS: ____

OBSTETRICIAN/MIDWIFE: ___________________________ PEDIATRICIAN/FAMILY MD: ___________________________

DATE OF LAST VISIT TO MD: __________________ PURPOSE: ____

IMMUNIZATION HISTORY: ____

HAS YOUR CHILD EVER BEEN TREATED ON AN EMERGENCY BASIS?: ____________________________________

DESCRIBE: ____

CHILDHOOD DISEASES: CHICKENPOX _____ RUBELLA _____ MUMPS _____ MEASLES _____

RUBEOLA _____ WHOOPING COUGH _____ OTHER ________________________

HAS THIS CHILD EVER SUFFERED FROM: (PLEASE CHECK ALL THAT APPLY)

- ☐ DIZZINESS
- ☐ DIABETES
- ☐ ARTHRITIS
- ☐ NEURITIS
- ☐ ANEMIA
- ☐ POOR APPETITE
- ☐ BED WETTING
- ☐ FAINTING
- ☐ NECK PROBLEMS
- ☐ JOINT PROBLEMS
- ☐ ALLERGIES
- ☐ MUSCLE JERKING
- ☐ BEHAVIORAL PROBLEMS
- ☐ BACKACHES
- ☐ TUBERCULOSIS
- ☐ HEADACHES
- ☐ DIGESTIVE DISORDERS
- ☐ RHEUMATIC FEVER
- ☐ HYPERACTIVITY
- ☐ CONVULSIONS
- ☐ WALKING PROBLEMS
- ☐ ARM PROBLEMS
- ☐ CHRONIC EARACHES
- ☐ CONSTIPATION
- ☐ RUPTURES/HERNIAS
- ☐ HEART TROUBLE
- ☐ HYPERTENSION
- ☐ ASTHMA
- ☐ SINUS TROUBLE
- ☐ ORTHOPEDIC PROBLEMS
- ☐ SUGAR CONCENTRATION
- ☐ PARALYSIS
- ☐ BROKEN BONES
- ☐ LEG PROBLEMS
- ☐ COLDS/FLU
- ☐ DIARRHEA
- ☐ "GROWING PAINS"

SURGERY: ____

MEDICATIONS: ____

ACCIDENTS: ____ WT. OF BACKPACK _______________LBS.

AUTHORIZATION OF CARE OF MINOR

I HEREBY AUTHORIZE THIS CHIROPRACTIC OFFICE AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON/ DAUGHTER/ WARD (UPON APPROVAL OF PARENT OR GUARDIAN)
I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS CLINIC AND THAT I WILL PAY FOR ALL SERVICES AS THEY ARE PERFORMED. X-RAYS REMAIN THE PROPERTY OF THIS OFFICE.

SIGNED: ____ DATE: ______________________________

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease and infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I,__________________________ have read and fully understand the above statements.
(print name)

All questioning regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_________________________________ _______________
(signature) (date)