Print Form

PERSONAL INFORMATION

Patient Name _____ Date _____

Phone # _____ Cell # _____ Work # _____ E-mail _____

Address _____ City _____ State _____ Zip _____

DOB _____/_____/_____ Age _____ Sex: ☐ M ☐ F Height: _____ Weight: _____

SS # _____ # of Children _____ Names/Ages of Siblings _____

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 OR ENJOYING:

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

☐ OTHER: _____

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)