



ABOUT THE CHILD

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	
[REDACTED]	
DATE OF BIRTH:	AGE:
SOCIAL SECURITY NUMBER:	
GENDER:	WEIGHT:

ABOUT THE PARENT

PARENT NAME:	
ADDRESS:	
<input type="checkbox"/> SAME AS ABOVE	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
[REDACTED]	
EMPLOYER NAME:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:
[REDACTED]	
INSURANCE COMPANY:	
INSURED'S NAME	
INSURED'S SOCIAL SECURITY NUMBER:	
INSURED'S DATE OF BIRTH	

VACCINATIONS

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED: <input type="checkbox"/> DPT <input type="checkbox"/> MMR <input type="checkbox"/> CHICKEN POX <input type="checkbox"/> HEPATITIS <input type="checkbox"/> OTHER
DESCRIBE ANY AND ALL REACTIONS TO VACCINE (S):

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (ALL THAT APPLY): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:
HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?
HAS ANY CHILD IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> OTHER PLEASE EXPLAIN:
WHEN DID THIS CONDITION BEGIN?
HAS THIS CONDITION: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONDITION INTERFERE WITH: <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS:

MOTHER'S PREGNANCY & LABOR

DURING PREGNANCY DID YOU USE:	
<input type="checkbox"/> DRUGS/MEDICATIONS	<input type="checkbox"/> TOBACCO/ALCOHOL
IF YES, PLEASE EXPLAIN:	
DESCRIBE YOUR DELIVERY:	
<input type="checkbox"/> LABOR WAS CHEMICALLY INDUCED	<input type="checkbox"/> LABOR WAS DOCTOR ASSISTED
<input type="checkbox"/> C-SECTION DELIVERY	<input type="checkbox"/> FORCEPS/VACUUM EXTRACTION
<input type="checkbox"/> DOCTOR PULLED OR TWISTED BABY	<input type="checkbox"/> PREMATURE DELIVERY
PLEASE EXPLAIN:	
DID YOU EXPERIENCE ANY ILLNESS(S) WHILE PREGNANT?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO
PLEASE EXPLAIN:	
DID YOU NURSE THE BABY?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO
DID YOU EXPERIENCE FEEDING PROBLEMS?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO
DID YOUR BABY HAVE COLIC?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO
VACCINATIONS?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO

CHILD'S CURRENT HEALTH STATUS

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
PLEASE EXPLAIN:		
HAS YOUR CHILD EVER BEEN HOSPITALIZED?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
PLEASE EXPLAIN:		
HAS YOUR CHILD EVER HAD A SEVERE FALL?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
PLEASE EXPLAIN:		
HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
PLEASE EXPLAIN:		
IS YOUR CHILD ACCIDENT PRONE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
PLEASE EXPLAIN:		
HAS YOUR CHILD EVER HAD SURGERY?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
PLEASE EXPLAIN:		
IS YOUR CHILD CURRENTLY TAKING MEDICATIONS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
PLEASE EXPLAIN:		
DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS?		
<input type="checkbox"/> YES	<input type="checkbox"/> NO	PLEASE EXPLAIN:
HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR?		
<input type="checkbox"/> YES	<input type="checkbox"/> NO	PLEASE EXPLAIN:
WHAT CHANGES (IF ANY) IN YOUR CHILD'S HEALTH OR BEHAVIOR WOULD YOU LIKE ACCOMPLISHED?		

CHILD'S HEALTH HISTORY

INSTRUCTIONS: *Please check each of the diseases or conditions that the child now or had 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"/> CONSTIPATION	<input type="checkbox"/> IRRITABILITY
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DIGESTIVE PROBLEMS	<input type="checkbox"/> SKIN PROBLEMS
<input type="checkbox"/> ATTENTION PROBLEMS	<input type="checkbox"/> EAR PROBLEMS	<input type="checkbox"/> SLEEPING DISORDERS
<input type="checkbox"/> BED WETTING	<input type="checkbox"/> FREQUENT COLDS	<input type="checkbox"/> TUBES IN THE EARS
<input type="checkbox"/> BREATHING PROBLEMS	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> VISION PROBLEMS
<input type="checkbox"/> COLIC	<input type="checkbox"/> HYPERACTIVITY	<input type="checkbox"/> OTHER:

CHIROPRACTIC AWARENESS

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM?	THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS?
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD?	IF CHIROPRACTIC CARE STARTS AT BIRTH, YOU CAN ACHIEVE A HIGHER LEVEL OF HEALTH THROUGHOUT LIFE?
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care, To work with my condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Dr. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

PARENT OR GUARDIAN AUTHORIZING CARE SIGNATURE:

DATE:

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):

RELATIONSHIP TO PATIENT:

SIGNATURE:

DATE: