NEW PATIENT APPLICATION FOR CHILD

Welcome to our practice! Please thoroughly complete all questions. Thank you!

Child's Name____ Today's Date_____/_____/_____

Birthdate_____/_____/_____ Age_____ Height _______ Weight _______ M __ F __

Address______________________________ City/State/Zip_____________________________________

Mother's Name _______________________
Employer_____________________________
Marital Status: S/M/D/W (circle one)
Home Phone (_____)__________________
Work Phone (_____)__________________
Cell Phone (_____)__________________
E-Mail _______________________________

Father's Name _________________________
Employer______________________________
Marital Status: S/M/D/W (circle one)
Home Phone (_____)____________________
Work Phone (_____) ____________________
Cell Phone (_____) ____________________
E-Mail _________________________________

Name & Age of Sibling(s) ____

Who may we thank for referring you?____

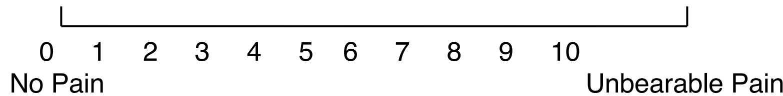
Health Reasons For Consulting Our Office:

1.__________________________ 3.____________________________

2.__________________________ 4.____________________________

Has your child had similar problem(s) before? _____Yes _____No

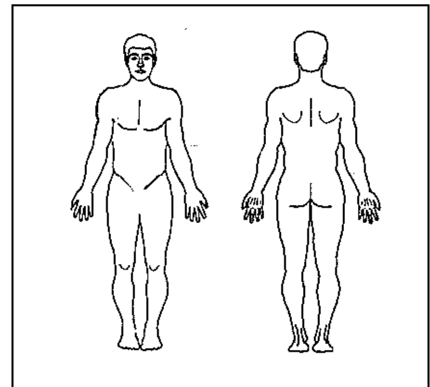
Current Complaint (how your child feels today): Please Circle



0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

Mark Area of Health Concerns



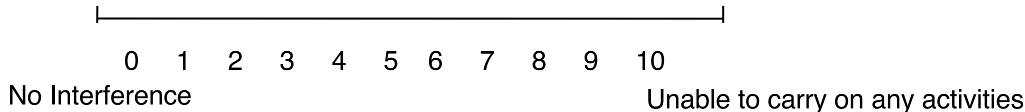
Front Back

How often are your child's symptoms present?

(Occasional) ___ 0-25% ___26-50% ___51-75% ___76-100% (Constant)

How long have your child's symptoms been present?_______________________________________

In the past week, how much has your child's problem interfered with their daily activities?
(for example work, social activities, household chores) Please Circle



0 1 2 3 4 5 6 7 8 9 10

No Interference Unable to carry on any activities

Previous Chiropractor __________________________Last Visit________________________________
Reason for care ____

General Practitioner ___________________________ and city____________________________

Has your child had any (circle all that apply) X-rays, MRI, CT Scan for your area(s) of complaint?
___Yes ___No Date Taken____________ What areas were taken?________________
Is this the result of an auto injury? ___Yes ___No If so, when? ________________

Other Doctors who have treated this problem____

Father/Mother/Brother/Sister/Children, with similar problems?_______________________________

Please check all of the following that apply to your child.

___Alcohol/Drug Dependence
___Recent Fever
___Diabetes
___High Blood Pressure
___Stroke (Date)__________
___Corticosteroid Use (Cortisone, Prednisone, etc.)
___Taking Birth Control Pills
___Dizziness/Fainting
___Numbness in Groin/Buttocks
___Epilepsy/Seizures
___Menstrual Problems
___Urinary Problems
___Currently Pregnant, # Weeks ___
___Abnormal Weight ___Gain ___Loss
___Marked Morning Pain/Stiffness
___Pain Unrelieved by Position or Rest
___Pain at Night
___Visual Disturbances
___Tobacco Use – Type_______________Frequency_______________/Day
___Cancer/Tumor (Explain)____
___Surgeries____
___Medications____
___Other Health Problems (Explain)____
___None of the Above

Parents:
What have you heard about chiropractic?____

Do you know what a subluxation is? ___Yes ___No

If yes, please describe____

What daily rituals for spinal health do you presently practice?_________________________________

Do you have health insurance? ___Yes ___No Insurance Plan____________________________
Method of Payment for First Visit: ___Cash ___Check ___Credit Card

I would like my child to experience the following benefits from Chiropractic Care:
___ Symptomatic relief of pain or discomfort
___ Correction of the cause of the problem as well as relief of symptoms
___ Prevention of future problems
___ Healthier spine and nerve system
___ Optimal health on all levels
___ Other - Please explain ____________________________________

The above information is true and accurate to the best of my knowledge. My reasons for consultation with the Doctor is for the evaluation of my physical health and potential for improvement.

Parent or Guardian Signature: _______________________________________Date: ___/____/_____