WELCOME

CHILD'S PERSONAL INFORMATION

Child Name: ____Preferred Name: ____

Birthdate: _____/ _____ /_____Age: __________ □ Male □ Female Weight: _______lbs. Height: _____Ft. _____In.

Mailing Address: ____________________________________City: _______________________State: ___________Zip:_______________

Primary Contact Number: _______________________________ Email: ____

Referred By: ____

Text Reminders: You will receive a text four hours before your child's reserved appointment.

REASON FOR VISIT

What is your child's primary pain/complaint? ____

____

Describe the quality of your primary pain/compliant, is it (circle any that apply): burning, crushing, dull, sharp, tearing, or tingling?

*Is there any pattern to the quality of your pain, such as (circle all that apply): constant, intermittent, or throbbing?

*On a scale of 0-10, with 10 being the greatest pain, what is your child's pain rating when they are suffering (circle): 0 1 2 3 4 5 6 7 8 9 10?

What date did you or your child first notice your child's primary pain/complaint? ____

____

Did something cause your child's primary pain/complaint to begin? ________________ ____

____

If you saw any doctor or health care practitioner for your primary pain/compliant, please list their names and what they did, or prescribed, for you:

Doctor/Health Practitioner's Name:	What they did, or prescribed, for you:

Parent's Names:____

Does your child have any siblings? (Circle an answer): Yes No If yes, please list their name(s) and age(s):

Name:	Age:

HEALTH HISTORY

Is your child taking any of the following medications?

□ Nerve Pills	□ Pain Killers (Including Aspirin)	□ Muscle Relaxers	□ None
□ Blood Thinners	□ Stimulants	□ Insulin	□ Other (s)

Does your child have or ever had any of the following conditions? (Please check all that apply.) □ None

□ Heart Attack	□ Heart Surgery/Pacemaker	□ Heart Murmur	□ Congenital Heart Defect
□ Mitral Valve Prolapse	□ Artificial Valves	□ Alcohol/Drug Abuse	□ Venereal Disease
□ Hepatitis	□ HIV+/AIDS	□ Shingles	□ Cancer
□ Frequent Neck Pain	□ Emphysema/Glaucoma	□ Anemia	□ High/Low Blood Pressure
□ Psychiatric Problems	□ Rheumatic Fever	□ Severe/Frequent Headaches	□ Kidney Problems
□ Ulcers/Colitis	□ Fainting/Seizures/Epilepsy	□ Sinus Problems	□ Asthma
□ Diabetes/Tuberculosis	□ Difficulty Breathing	□ Chemotherapy	□ Lower Back Problems
□ Artificial Bones/Joints	□ Arthritis	□ Constipation	□ Diarrhea

Please list any other serious medical conditions your child has or ever had: ____
____

Allergies: ____

Has your child ever been involved in a serious accident? (Circle an answer) Yes No If yes, please list them below:

Type of Accident:	Date Happened:

Is your child pregnant? □ Yes □ No How long? _______________

CONSENT TO CHIROPRACTIC CARE OF A MINOR CHILD

- You are invited to discuss, with staff, any questions regarding services in the office. The best health services are based on friendly, mutual understanding between provider and patient.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office.)
- I hereby authorize the Dr.'s of Ideal Chiropractic Health Center and whomever he may designate as his assistants to examine and administer chiropractic care as he so deems necessary to my son/daughter, (Child's name) ____

Parent/Guardian Signature: ____ Date: ______________________________