Welcome to High Point Chiropractic

BIRTH – 17 YEARS OF AGE

PATIENT'S NAME ____ DATE ________________

PARENT/GUARDIAN NAME ______________________________ RELATIONSHIP ____________________

ADDRESS _______________________________ CITY/STATE __________________ ZIP _____________

HOME PHONE ____________________________ MOBILE PHONE _________________________________

WORK PHONE/S ______________________________________ PATIENT'S BIRTHDATE _______________

E-MAIL ADDRESS _______________________________ WHO REFERRED YOU TO US? ______________

PAST CHIROPRACTIC CARE? YES/NO DR.'S NAME/LOCATION ____________________________________

____ LAST VISIT _____________

CURRENT MEDICAL CARE? YES/NO WHY? ____

CURRENT DRUGS/MEDICATION ____

PAST SURGERIES: ____

FEMALE: PREGNANT? ____ NURSING? ____ TAKING BIRTH CONTROL PILLS? ____

Health history (Please check all that apply to your child's current and/ or past health)

__ Illness during pregnancy
__ Drugs/medicine/tobacco/alcohol during pregnancy
__ Premature delivery
__ Labor chemically induced
__ Pulling or twisting during delivery
__ Forceps/vacuum extraction/c-section
__ Jaundice treatment
__ Eating or nursing problems
__ Falls in first year of life
__ Vaccinations
__ Colic
__ Fever

__ Digestive problems
__ Sleeping problems
__ Limited exercise
__ Surgery
__ Non-prescription drug use
__ Prescription drug use
__ Bed wetting
__ Neck pain
__ Family/home stress
__ Other falls or injuries
__ Any major illness

__ Ear infections
__ Hyperactivity
__ Reoccurring illnesses
__ Ever hospitalized
__ Sports injury
__ Auto accident or injury
__ Headaches
__ Allergies/Asthma
__ Poor nutrition
__ Respiratory problems
__ Any other health problems

Explain: ____

____

Addressing the Issue That Brought You to the Office

If your child has no symptoms or complaints, and they are here for wellness services, please check here ____ "**Wish to have chiropractic Wellness Services**" and skip to "**Family Health Profile**." Others need to briefly describe the chief area of complaint, including the effect it has had on your child's life. _______________________________

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If your child is experiencing pain, is it…

___ Sharp ___ Dull ___Comes/goes ___Travels ___Constant

Since the problem started, it is… ___ About the same ___Worse ___Better

What makes it worse: ____

Yes, it interferes with: ___School ___Sleep ___Walking ___Sitting

___Hobbies ___Leisure ___Other: ____________

Other Doctors seen for this problem (please list):

Chiropractor: ____

Medical Doctor: ____

Other: ____

PLEASE CHECK THE <u>ONE</u> CHOICE THAT MOST CLOSELY DESCRIBES YOUR CURRENT GOALS FOR YOU CHILD'S HEALTH/WELLBEING.

- ❑ I am only concerned about relief of a particular symptom.
- ❑ I am only concerned about relief of a particular symptom, and preventing its return.
- ❑ I want optimum health and wellbeing on every level for my child.

Daily Habits:

What type of exercise does your child perform on a daily basis? ______________________________

Does your child belong to a health club or athletic team? ___ Yes___ No If yes, which one? ________________

What vitamins or supplements does your child currently take? ______________________________

How many caffeinated beverages does your child consume per day? ____________________________

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children:______________________________ Spouse: ______________________________

Mother:______________________________ Father: ______________________________

Brothers:______________________________ Sisters:______________________________

Others: ____

To the best of my knowledge, the about information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health. I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing.

I certify that I, and/or my dependent(s), have insurance coverage with ___________________________ And assign directly to High Point Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

High Point Chiropractic may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ______________________

Signature of patient, guardian or personal representative date

____ ______________________

Please print name of patient, parent, guardian, or personal representative relationship to patient