IMPULSE CHIROPRACTIC

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Patients Information: Preferred Name/Nickname:_____

Child's First Name: _____ **Middle Initial**: _____ **Child's Last Name**: _____

Address: _____ **City:** _____ **Prov:**_____ **Postal Code:** _____

Care Card Number: _____ **Birthdate (m/d/yr)** _____/_____/ _____ **Age:**_____

Mother's Name: _____ **Father's Name:** _____

Mother's Cell Number: _____ **Father's cell Number:**_____

Parents' Email: _____

Birth Weight: _____ **Current Weight:** _____ **Height:** _____ **Number of Siblings:** _____

Type of Birth: ☐ **Normal Vaginal Birth** ☐ **Home Birth** ☐ **Forceps** ☐ **Hospital Birth** ☐ **Breech** ☐ **Caesarean** ☐ **Suction**

Problems During Pregnancy, Labor and Delivery: _____

_____

_____

Reason For Visit: _____

_____

Health History:

Jaundice at Birth: Yes No Cyanosis at Birth: Yes No

Congenital Anomalies or Defects: _____

_____

Quality of Sleep: ☐ **Good** ☐ **Fair** ☐ **Poor**

Number of Hours of Sleep per Night: _____

Family Doctor / Pediatrician: _____

Obstetrician / Midwife: _____

Immunization History: _____

_____

Who can we thank for this referral?

☐ **Patient from this office (name)**

_____

☐ **Other Health Care Professional (name)**

_____

☐ **Walk By**

☐ **Website**

☐ **Sign**

☐ **Google**

☐ **Other internet search engine**

☐ **Other (specify)** _____

Childhood Disease:

☐ **Chicken Pox** ☐ **Mumps** ☐ **Measles** ☐ **Rubella** ☐ **Rubeola** ☐ **Whooping Cough** ☐ **Other: _____**

Symptoms and Ill Health:

Please circle either C for Current or P for Past diseases or conditions your child might have now or have had in the

C P - Dizziness	C P - Poor Appetite	C P - Allergies	C P - Leg Problems
C P - Backache	C P - Hyperactivity	C P - Behavioral Problems	C P - Constipation
C P - Chronic Earaches	C P - Colds / Flu	C P - Fainting	
C P - Diarrhea	C P - Joint Problems	C P - Sinus Trouble	
C P - Anemia	C P - Bed Wetting	C P - "Growing Pains"	
C P - Headache(s)	C P - Asthma	C P - Neck Problems	

Has your child undergone any medical care?_____

What medications is your child currently taking? _____

Surgeries? _____

History of Accidents or injuries: _____

_____

Fee Schedule:

Initial Consultation Fee: $98.00
Subsequent Visit Fee: $65.00
X-ray Fee: $37.50 per view
Nervous System Scan: $75.00
FOB or ID Card: $5.00 (Refundable with un-damaged devices)

I the undersigned, understand that the services rendered in this office are the responsibility of myself, should medical services plan or other third party plan fail to pay all or part of the amount due. I understand 24 hours notice is requested for cancellation of an appointment. I, the undersigned, also understand that each Practitioner is an independent and separate practice operating under Impulse Chiropractic and Massage Therapy Clinic. I hereby authorize the doctors in this clinic to examine my condition and render care as deemed necessary. In the event that X-rays are necessary in my case, I understand and agree that X-rays taken in this clinic are the property of Impulse Chiropractic Clinic, and will remain in this clinic where they can be reviewed for me by the Doctors. I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that fees for professional services are due when rendered. I understand that if I suspend or terminate my care, any fees for professional services will become immediately due and payable.

Childs name: _____

Parent or Guardian's Signature Authorizing Care: _____ Date: _____