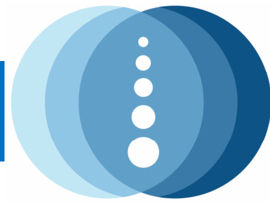

ABOUT THE CHILD

Name ______________________________

What is your child's preferred name?

____

Address______________________________

City ________________ State ___ Zip_______

Parent's phone______________________________

Birth date ________________ Age _______

ABOUT THE PARENT

Name ______________________________

Employer ______________________________

Work address ______________________________

Cell phone ______________________________

Home phone ______________________________

Type of work ______________________________

E-mail address ______________________________

REASON FOR THIS VISIT

What is the purpose of this visit?

____

Is the purpose of this appointment related to:

General Health and Wellness

Sports **Fall** **Injury** **Other**

Please explain ______________________________

If present: When did this condition begin?

Has this condition:

Gotten worse **Stayed constant** **Comes & Goes**

Does this condition interfere with:

Sleep **Daily routine** **Other activities**

Please explain ______________________________

____

Has this condition occurred before? **Yes** **No**

Please explain ______________________________

Have you seen other doctors for this condition? **Yes** **No**

Doctor's Name(s) ______________________________

Type of treatment ______________________________

Results ______________________________

CHIROPRACTIC PRINCIPLES

Were you aware that	Yes	No
* Doctors of Chiropractic work with the nervous system?	☐	☐
* The nervous system controls all bodily functions and systems?	☐	☐
* 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?	☐	☐

Continue on Back

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and the care plan.

- ◊ Allergies
- ◊ Asthma
- ◊ Attention problems
- ◊ Bed wetting
- ◊ Breathing problems/ Colic
- ◊ Constipation
- ◊ Digestive problems
- ◊ Ear problems
- ◊ Frequent colds
- ◊ Headaches
- ◊ Hyperactivity
- ◊ Irritability
- ◊ Skin problems
- ◊ Sleeping disorders
- ◊ Tubes in ears
- ◊ Vision problems
- ◊ Other ____________

MOTHER'S PREGNANCY & LABOR

During Pregnancy did you use:

☐ Drugs / Medicine ☐ Tobacco / Alcohol

Please explain ______________________________

Any illness during your pregnancy? ______________

____

How was your delivery? ________________________

- ☐ Labor chemically induced
- ☐ C-section delivery
- ☐ Did Dr. pull/twist baby
- ☐ Labor was Dr. assisted
- ☐ Forceps/Vacuum extraction
- ☐ Premature delivery

Are you / did you nurse the baby? **Yes No**

Are you / did your baby have colic? **Yes No**

Feeding problems? **Yes No**

Does / Did the baby favor one breast? **Yes No**

CHILD'S CURRENT HEALTH STATUS

	No	Yes	If Yes, please explain
Has your child ever:			
…taken antibiotics?	☐	☐	______________
…been hospitalized?	☐	☐	______________
…had a severe fall?	☐	☐	______________
…been in a car accident?	☐	☐	______________
Had Surgery? Please Explain…			
…currently taking any medication (s)?	☐	☐	______________
…having difficulty interacting with others?	☐	☐	______________

What changes (if any) in your child's health or behavior would you like accomplished?

____

VACCINATIONS

Have you chosen to vaccinate your child?

Yes No

If yes, circle all that your child has received.

DPT MMR Chicken Pox

Hepatitis Other

Describe all reactions to vaccine(s).

____

____

CHIROPRACTIC EXPERIENCE

Whom may we thank for referring you to this office?

____

Have you been adjusted by a Chiropractor before? **Yes No**

Reason for those visits? ________________________

Doctor's name ______________________________

Approximate date of last visit ____________________

Has any adult in your family seen a Chiropractor? **Yes No**

Has any child in your family seen a Chiropractor? **Yes No**

AUTHORIZATIONS

FEES AND INSURANCE

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable.

I authorize the use of this signature to allow the insurance companies to pay Vital Health Wellness Center directly any amounts payable as my assignment of benefits. I authorize the use of this signature on any insurance submissions.

NOTICE OF PRIVACY PRACTICES

By subscribing my name below, I acknowledge receipt of copy of the Notice of Privacy Practices by Vital Health Wellness Center that was revised on April 1, 2003

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 child's condition through the use of adjustments and procedures the doctor deems appropriate.

Name of Parent or guardian: ____

Signature of parent or guardian: ____

Date: ____________________________