Child's Application for Care at Reese Chiropractic & Wellness P.C.

For office use only
Patient #: ____________
Doctor: ____________
Date: ____________

ABOUT YOUR CHILD:
Name: ____________
Date of Birth: ____________ Age: ____________ Male ☐ Female ☐
Mother's Name: ____________ Father's Name: ____________
Address: ____________ City: ____________ State: ____ Zip: ____
Home Ph: ____________ Work Ph: ____________ Cell Ph: ____________
Email Address: ____________
Reason for consulting our office: ____________
Do you have insurance? ____________
Whom may we thank for referring you? ____________

HEALTH PROFILE:
If your child has no symptoms or complaints, and here is for wellness services, please check here ☐.
If there are sypmtons and complaints, briefly describe the chief area of complaint, include the effect it has on the child.
____
____
If he/she is experiencing pain, is it: ☐ Sharp ☐ Dull ☐ Comes and Goes ☐ Travels ☐ Constant
Since the problem started, is it: ☐ About the same ☐ Getting better ☐ Getting worse
What makes it worse? ____________
It interferes with: ☐ School ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Other:
Other doctors seen for this problem:
Chiropractor: ____________
Medical Doctor: ____________
Other: ____________

List medications the child is taking or surgeries the child has had: ____________
____
____
____
____

Daily we experience physcial, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effecs are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to your child's potential.

PREGNANCY:
Were there any complicaitons to the pregnancy? ____________
Was mom on any medications, prescription, or over-the-counter? ☐ Yes ☐ No
If yes, explain: ____________
Did mom or dad smoke during pregnancy? ☐ Yes ☐ No If yes, who: ____________
Was the baby ever in breech position? ☐ Yes ☐ No
How many ultrasounds were preformed? ____________

BIRTH AND DELIVERY:

Where was the baby born? ☐ Home ☐ Hosptial ☐ Birthing Center ☐ Other

Was the delivery? ☐ Vaginal ☐ C-section

Were any devices used? ☐ Forceps ☐ Vacuum

How long was labor? ______

How long was the delivery? ______

Was oxytocin/pitocin used? ☐ Yes ☐ No

Was an epidural administered? ☐ Yes ☐ No

INFANCY:

Was the infant vaccinated? ☐ Yes ☐ No

Was there any prolonged use of medicines or an inhaler? ☐ Yes ☐ No

If yes, which: ______

Did the infant suffer any traumas such as serious falls or car accidents? ☐ Yes ☐ No

Has the infant been under regular chiropractic care? ☐ Yes ☐ No

CHILDHOOD YEARS:

Did the child have any childhood illensses? ☐ Yes ☐ No Explain: ______

Does the child play youth sports? ☐ Yes ☐ No Explain: ______

Has the child had any surgery? ☐ Yes ☐ No Explain: ______

Has the child fallen from a height over 3 feet? ☐ Yes ☐ No Explain: ______

Was the child involved in any car accidents? ☐ Yes ☐ No When: ______

Has there been any prolonged use of meds? ☐ Yes ☐ No Explain: ______

Has the child suffered emotional traumas? ☐ Yes ☐ No Explain: ______

Please give us any other health information you feel would be helpful: ______

______

______

CONSENT FOR TREATMENT:

REGARDING ADJUSTMENTS, MODALITIES, & THERAPEUTIC PROCEDURES. The statemetns made on this form are accurate to the best of my recollection. I have been advised that chiropractic care, like all froms of heatlch care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chirpractic adjustments.

Treatment objectives as well as the risks assocated with chiropractic adjustments and, all other procedures provided at Reese Chiropractic & Wellness P.C. have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

ASSIGNMENT OF BENEFITS:

I hereby authorize payment to be made directly to Reese Chiropractic & Wellness P.C., for all benefits which may be payable under a healthcare plan or from any other collateral soruces. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of my payment liability and that I will remain financially responsible to Reese Chiropractic & Wellness P.C. for any and all services I receive at this office.

______ *Date:* ______

Patient or Authorized Person's Signature

______ *Date:* ______

Doctor's Signature