

CHILD NEW PATIENT APPLICATION

WELCOME TO OUR OFFICE. WE THANK YOU FOR YOUR TRUST!

(Please print using **black or blue ink**. If there is something that does not apply to you please put **N/A** on the line.)

Section 1: Patient Information

Appt. Date: _____ Referred By: _____

Name (first, middle, last): _____

Preferred Name: _____ Male Female Date of Birth: ___/___/___ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ /Carrier _____ Home Phone: _____ Work Phone: _____

Social Security Number: _____ Marital Status: Married Single Divorced Widow

Employer: _____ Occupation: _____ Email: _____

Name of Spouse/Significant Other: _____ Name & Ages of Children: _____

Emergency Contact: _____ Relationship _____ Phone # (____) _____

To conserve resources, we generally utilize Email and text for regular communication.

May we communicate with you via Email? Yes No | Text Yes No

1. Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office?

Friend/Family Member Name: _____

Telephone Call Yellowpages Sign Website Presentation E-mail

2. Spinal problems can cause a variety of health problems. Please check the health complaint(s) your child is currently experiencing or experiences on a periodic basis:

- | | | | |
|-------------------------------------|---|---|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Allergies | <input type="checkbox"/> Spinal Curvature | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Indigestion | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Arthritis | <input type="checkbox"/> _____ |

2. What is your child's primary health concern? _____

3. Research shows that spinal problems often begin at birth. How old was your child when they received their first chiropractic checkup? Never 0-2 Years 2-5 Years 5-12 years

4. Difficult, long and/or doctor-assisted births can cause spinal misalignments. Was your child born vaginally, by C-section, forceps, suction cup or other device? (Please circle one)

5. How long was the actual labor and delivery time? 0-3 hours 3-12 hours 12-24 hours >24 hours

6. Have you ever been told that your child has a spinal curvature, apinal arthritis or onherited spinal problem?
 Yes No

7. Poor posture can lead to poor health and usually indicates a spinal problem. How would you rate your child's posture?

Poor 1 2 3 4 5 6 7 8 9 10 Very Good

8. Did your child have early health challenges such as colic, irritability or frequent ear infections? Yes No

9. Does your child have other health problems that concern you? _____
10. Do you miss work or sleep often due to our child's illness(s)? Yes No
11. Do you worry often about your child's health? Yes No
12. Do you have any health problems that affect your family? Please list: _____

13. Is your child currently taking prescription medication? Yes No If so, how many? _____
14. Falls, sports impacts and auto accidents can cause serious spinal problems. Is this visit related to a fall, sports impact, auto accident or injury? Yes No Date of Incident: _____
15. If the doctor feels that your child will benefit from chiropractic care are you willing to follow his/her recommendations?
 Yes No

Section 2: History of Concern

Primary Concern(s): _____

Secondary Concern(s): _____

Tertiary Concern(s): _____

Auto and work-related injuries can cause serious spinal problems. Are your complaints due to an Accident? YES NO

If yes, what type? Work Auto Personal Date of Accident _____ If Work or Auto

accident, have you reported this accident to anyone? Yes No Who was it reported to? _____

Have you seen any doctors for this condition: YES NO

Please list the doctor specialty, & for how long you were seen. _____

Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking? (Prescription and non-prescription)

Section 3: Family History:

Does anyone in your family suffer with the same condition(s) or other chronic illnesses? No Yes

If yes whom & what condition(s): _____

The above information is true and accurate to the best of my knowledge. Copies of any x-rays and reports will be released upon written request, however original x-rays remain the property of the clinic.

Patient/Guardian's Signature: _____ Date: ____/____/____

Doctor's Signature _____ Date Form Reviewed: ____/____/____

Patient Name _____ **DOB:** _____

Section 4: Past Trauma History: Starting from birth, we all experience thousands of physical, mental, & chemical stresses. These stresses can cause *Postural Distortions* (misalignments of the spine) and lead to our current health problems.

Please write down some of the falls, injuries, & traumas that you've experienced. (Please put NA if it doesn't apply to you)

A. Car Accidents (List even minor ones. A 5mph crash from a 3000lb vehicle can cause damage to your spine even if you didn't *feel* injured!)

Example: 12-1-2007 Type of Collision: **Front end** 10 mph Injuries: **Neck Whiplash/Neck on Rt. side**
 Date: ___/___/___ Type of Collision: Front Side Rear Speed _____ Injuries: _____ Lt Rt
 Date: ___/___/___ Type of Collision: Front Side Rear Speed _____ Injuries: _____ Lt Rt

B. Sports Injuries (if there are too many to list please write the name of the sport and "MANY" next to it.)

Example: 1-1-2008 Type of Sport: **Basketball** Type of Injury: **Sprained Right Knee**
 Date: ___/___/___ Type of Sport _____ Type of Injury: _____ Lt Rt
 Date: ___/___/___ Type of Sport _____ Type of Injury: _____ Lt Rt

C. Slips, falls, & Bike Accidents (We understand there may have been a lot of slips & falls since birth, so please list the major ones.)

Example: 2-1-2008 Type of Injury: **Slipped on ice & bruised Left Elbow**
 Date: ___/___/___ Type of Injury: _____ Lt Rt
 Date: ___/___/___ Type of Injury: _____ Lt Rt

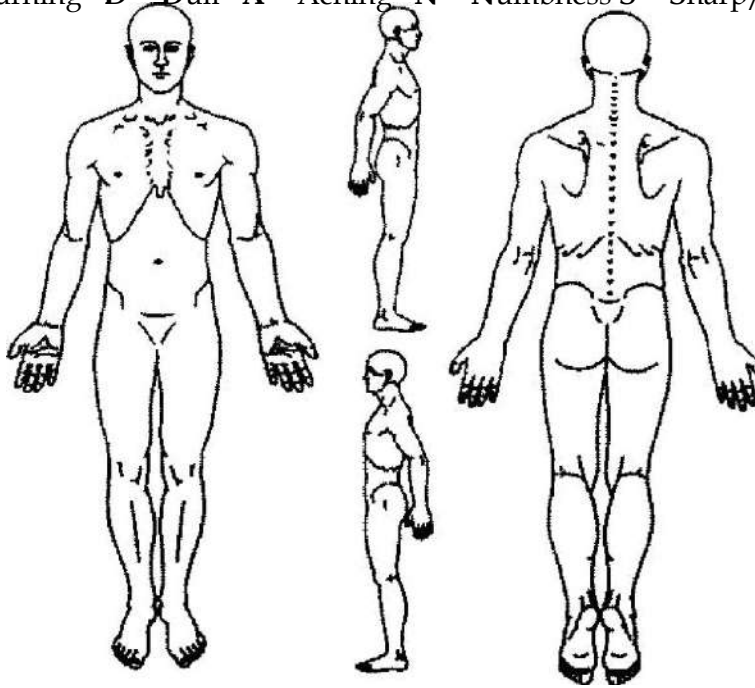
D. Repetitive Injuries (Please list all repetitive injuries you've had in the past.)

Example: 3-1-2008 Type of Injury: **Lifting boxes injured lower back**
 Date: ___/___/___ Type of Injury: _____ Lt Rt
 Date: ___/___/___ Type of Injury: _____ Lt Rt

Exam

*PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:

R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/ Stabbing T = Tingling



Patient/Guardian's Signature: _____ Date: ___/___/___

Doctor's Signature _____ Date Form Reviewed: ___/___/___

Patient Name _____ DOB: _____

Section 5: Present and Past Conditions

Using the codes listed below, please fill in **EVERY** blank with the applicable letter.

Check to indicate if you have Pain or Stiffness and on which side of your body.

If **both** sides apply, please check **R & L**.

P = Past Health Issue **C** = Current Health Issue **N** = Never had this Health Condition

Example: C Shoulder Pain Stiff R L

Extremities	Location	Respiratory	Other Conditions	Male
<input type="checkbox"/> Hip <input type="checkbox"/> Pain <input type="checkbox"/> Stiff	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Asthma	<input type="checkbox"/> Headaches / Migraines	<input type="checkbox"/> Impotence
<input type="checkbox"/> Knee <input type="checkbox"/> Pain <input type="checkbox"/> Stiff	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Foot <input type="checkbox"/> Pain <input type="checkbox"/> Stiff	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Excessive Sweating	Female
<input type="checkbox"/> Shoulder <input type="checkbox"/> Pain <input type="checkbox"/> Stiff	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Cancer & Type: _____	<input type="checkbox"/> Menopausal Problem
<input type="checkbox"/> Elbow <input type="checkbox"/> Pain <input type="checkbox"/> Stiff	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> COPD	<input type="checkbox"/> Emotional / Mental Disorders	<input type="checkbox"/> Menstrual Cycle Problems
<input type="checkbox"/> Wrist <input type="checkbox"/> Pain <input type="checkbox"/> Stiff	<input type="checkbox"/> R <input type="checkbox"/> L	Digestion	<input type="checkbox"/> Learning Disability	
<input type="checkbox"/> Jaw Pain <input type="checkbox"/> Click <input type="checkbox"/> Pop	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Nervous / Irritable	
<input type="checkbox"/> Swollen or Painful Joints		<input type="checkbox"/> Digestion Problems	<input type="checkbox"/> Loss of Memory	Social History
Spine		<input type="checkbox"/> Gallbladder Problems	<input type="checkbox"/> Dizziness / Loss of Balance	<input type="checkbox"/> Smoking
<input type="checkbox"/> Head / Shoulders Feel Heavy / Tired		<input type="checkbox"/> Colon Trouble	<input type="checkbox"/> Arthritis	How much _____
<input type="checkbox"/> Neck <input type="checkbox"/> Pain <input type="checkbox"/> Stiff	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Diarrhea / Constipation	<input type="checkbox"/> Epilepsy / Convulsions	How Often _____
<input type="checkbox"/> Upper Back <input type="checkbox"/> Pain <input type="checkbox"/> Stiff	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Knocked Unconscious	
<input type="checkbox"/> Mid Back <input type="checkbox"/> Pain <input type="checkbox"/> Stiff	<input type="checkbox"/> R <input type="checkbox"/> L	Immune System	<input type="checkbox"/> Frequent Ear Infections	<input type="checkbox"/> Alcoholic Beverage Consumption
<input type="checkbox"/> Low Back <input type="checkbox"/> Pain <input type="checkbox"/> Stiff	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Ringing in Ear R / L	Occurs _____
<input type="checkbox"/> Pain with cough, sneeze, or strain with bowel movement LOCATION of Pain: _____		<input type="checkbox"/> Sinus Problems/ Allergies	<input type="checkbox"/> Hearing Loss R / L	<input type="checkbox"/> Recreational Drugs
Other: _____		<input type="checkbox"/> Frequent Colds / Flu	<input type="checkbox"/> Trouble Concentrating	What Used _____
		<input type="checkbox"/> Anemia	<input type="checkbox"/> AIDS / HIV	How Often _____
		<input type="checkbox"/> Other: _____	<input type="checkbox"/> Fracture / Dislocation of Bones: _____	<input type="checkbox"/> Exercise
		Organ Problems or Dysfunction	<input type="checkbox"/> Other: _____	Type _____
Numbness / Tingling or Pain In:		<input type="checkbox"/> Diabetes	Urinary Tract	How Often _____
<input type="checkbox"/> Arm <input type="checkbox"/> R <input type="checkbox"/> L		<input type="checkbox"/> Liver Trouble	<input type="checkbox"/> Kidney Trouble	
<input type="checkbox"/> Hand /Fingers <input type="checkbox"/> R <input type="checkbox"/> L		<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Frequent Urination	
<input type="checkbox"/> Legs <input type="checkbox"/> R <input type="checkbox"/> L		<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Bedwetting	
<input type="checkbox"/> Foot / Toes <input type="checkbox"/> R <input type="checkbox"/> L		<input type="checkbox"/> Heart	<input type="checkbox"/> Other: _____	

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Patient/Guardian's Signature: _____ Date: ____/____/____

Doctor's Signature _____ Date Form Reviewed: ____/____/____

Patient Name _____ DOB: _____

Section 6: Past Health Conditions

Transfer conditions from page 3 marked with a "P" for past health issue.

Please list: *when, how long it lasted, description of symptoms (ex. Sharp, pain, burning), how often (ex. Weekly, daily), severity (0=no pain; 10=worst pain).*

Past Health Issue: _____

Past Health Issue: _____

Past Health Issue: _____

Are any of these past conditions due to an accident? YES NO If yes, what type? Work Auto Personal

Date of Accident _____ Have you seen any doctors for this condition: YES NO

Please list the doctor specialty, & for how long you were seen. _____

List any past hospitalizations and/or surgeries:

Surgeries: _____

List Hospitalizations Other Than Surgeries: _____

The above information is true and accurate to the best of my knowledge. Copies of any x-rays and reports will be released upon written request, however original x-rays remain the property of the clinic

Patient/Guardian's Signature: _____ Date: ____/____/____

Doctor's Signature _____ Date Form Reviewed: ____/____/____

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