CHILD PRACTICE MEMBER FORM

AUTHORITY CHIROPRACTIC

OFFICE USE ONLY

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ABR	Y/N

PERSONAL INFORMATION

Child's Name : Gender: Male Female

Address : City: State: Zip Code:

Date of Birth : Age: Current Height: Weight:

Mother's Name: Mother's Date of Birth :

Mother's Mobile: Mother's Last 4 SSN: Father's Mobile:

Father's Name: Father's Date of Birth :

Pediatrician/Family MD: City/State:

Last Visit: Reason For Last Visit:

Who may we thank for referring you?

PURPOSE OF THIS VISIT

What health concerns bring you into our office? Wellness Checkup Injury or Accident Other:

Please explain:

Have you received care for this problem before? Yes No - If yes, when?

If Yes: Chiropractor Medical Doctor Other:

If Yes: Who? Results?

How did the problem(s) start? Suddenly Gradually Post-Injury

This condition is: Getting Worse Improving Intermittent Constant Unsure

If your child is experiencing pain/discomfort, please identify. where and for how long:

Please list any medications your child takes and for what reason:

Has your child ever sustained an injury playing organized sports? Yes No If yes, please explain:

Has your child ever sustained an injury in an auto accident? Yes No If yes, please explain:

Was your child born before 40 weeks gestation? ◯ Yes ◯ No If yes, please explain:

My child was born: ◯ Vaginal Birth ◯ Cesarean/C-Section

Did your child sustain any trauma during labor/delivery? ◯ Yes ◯ No If yes, please explain:

Covid Vaccine? ◯ Yes ◯ No

Other vaccine history: ◯ Fully ◯ Partially ◯ No Vaccines

HAS/DOES YOUR CHILD SUFFER FROM: *Check all that apply*

Past	Current	
☐	☐	Headaches
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Seizures/Convulsions
☐	☐	Heart Trouble
☐	☐	Chronic Earaches
☐	☐	Sinus Trouble
☐	☐	Scoliosis
☐	☐	Bed Wetting
☐	☐	Fall from bed or couch
☐	☐	Fall from high chair
☐	☐	Behavioral Problems
☐	☐	ADD/ADHD
☐	☐	Ruptures/Hernia
☐	☐	Muscle Pain

Past	Current	
☐	☐	Orthopedic Problems
☐	☐	Neck Problems
☐	☐	Arm Problems
☐	☐	Leg Problems
☐	☐	Joint Problems
☐	☐	Backaches
☐	☐	Poor Posture
☐	☐	Anemia
☐	☐	Broken Bones
☐	☐	Fall from crib
☐	☐	Fall from changing table
☐	☐	Growing Pains
☐	☐	Asthma
☐	☐	Hypertension
☐	☐	Sleeping Problems

Past	Current	
☐	☐	Digestive Disorders
☐	☐	Poor Appetite
☐	☐	Stomach Ache
☐	☐	Reflux
☐	☐	Colic
☐	☐	Latching/Feeding Difficulty
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Colds/Flu
☐	☐	Fall down stairs
☐	☐	Fall off slide/playground
☐	☐	Walking Trouble
☐	☐	Fall in baby walker
☐	☐	Fall off bicycle

☐ Other:

Please list any allergies:

Notes:

PAIN SCALE *Please complete for your child if applicable. (For reference, 0 = no pain and 10 = worst possible pain.)*

How would you rate your child's pain right now?

What is their typical or AVERAGE pain?

What is your child's pain level at its BEST? (How close to 0 does your child's pain get at its best?)

What is your child's pain level at its WORST? (How close to 10 does your child's pain get at its worst?)

ACKNOWLEDGEMENT

I understand that I am directly and fully responsible to Authority Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse, or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

PRINT NAME:

SIGNATURE: **DATE:**