New Patient Information

Name _____ Date _____ Date of Birth _____

Parents/Guardians Name _____ Number of Siblings _____

Address _____ City _____ State _____ Zip _____

Parent Primary Number ( ) _____ - _____ Parent Secondary Number ( ) _____ - _____

Parent Email _____

How did you hear about our office? _____

REASON FOR VISIT

What is your child's current complaint? _____

_____

How long has the child had this condition? _____

Has this occurred in the past? How many times? _____

What have you tried in the past that did not work? (medication, ice, heat, etc.) _____

_____

List all prescription and over the counter drugs that your child has taken in the past 30 days.

Name	Name
_____	_____
_____	_____
_____	_____

List any side effect that your child has experience from taken these medications: _____

_____

HISTORY

Has the child had a major fall or accident? ☐ No ☐ Yes, explain _____

_____

On average, how many times a year does your child have an illness that requires a trip to your medical doctor?

_____ Has your child ever taken antibiotics before? ☐ No ☐ Yes

On average, how many antibiotics does your child take per year?_____

Name of Pediatrician_____ Date of Last Visit ____/____/____

Reason for Visit _____

Turn Over

Mark any of the following conditions your child currently has **(+)** or has had in the past **(✓)**

__Digestive Problems __ADD/ADHD __Ear Infection __Scoliosis __Asthma

__Recurring Fevers __Temper Tantrums __Bed Wetting __Headaches __Colic

__Growing/Back Pains __Chronic Colds __Car Accident __ Seizures __ Other_____

Birthing History (please fill out if under age of 10)

Problems during pregnancy (mother or child): _____

_____

Please mark type of birth: ☐ Natural ☐ C-section ☐ Home Birth ☐ Other _____

Instruments used to aid labor: ☐ Vacuum ☐ Forceps ☐ Other _____

Problems with labor or birth: _____

_____

Breast Fed: Yes No How Long:_____

Formula Fed: Yes No How Long:_____

Food and/or Juice Allergies or Intolerances Yes No

Please List All Allergies_____

_____

Any other information that would be helpful to the Doctors _____

_____

_____

_____

My signature will give permission to Live Well Chiropractic to use any or all of the facts including my child's photograph on the "Wall of fame" in the Live Well Office, on Live Well Chiropractic Web site, Social Media or in studies and research data.

Print Minors name_____

Print Guardians name _____

_____

Signature (Guardian) **Date**

Dr. Kris Arnold
Dr. Jason Stephens
1634 Quaker Valley Road, New Paris Pa 15554
814-624-0606

TERMS OF ACCEPTANCE

When a patient seeks Chiropractic health care and we accept a practice member for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each practice member understands both the objective and the method that will be used to obtain it. This will prevent any confusion.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of subluxation. Our Chiropractic method of correction is by specific, gentle adjustments.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Subluxation: An impediment in the brain and nervous system which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to regulate and heal itself. Subluxations appear as the colored bars on the computer scans.

We do not offer to diagnose or treat any disease or condition other than subluxation. However, if during the course of a chiropractic examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct subluxations.

I, _____ being parent or legal guardian of _____
(Print Name) (Print Name)
have read and fully understand the above statements. I hereby grant permission for my child to receive chiropractic care.

_____ _____
Signature Date

I hereby authorize the release, use, or disclosure of my health information by Live Well Chiropractic for purposes of treatment, payment, or healthcare operations. I understand that I may revoke this authorization at any time in writing. This authorization will remain in effect unless otherwise stated by myself or LWC.
I understand that I may request a copy of the privacy policy of LWC.

_____ _____
Signature Date

You may discuss my health information with the following people:

_____ _____