Welcome To TRU Health Family Chiropractic

First Name _____ MI ____ Last _____ Birth Date____/____/____ Age_____ Today's date____/____/_____

Address _____City _____ State_____ Zip _____

Male ____ Female ____ Parent/Guardian Name(s) _____ Cell # ( )_____

E-mail Address _____ Emergency Contact _____ Emergency Contract # ( )_____

Pediatrician Name _____How did you hear about us? _____ Method of payment: *FSA HSA Cash Check CC*

What health condition(s) brings your child into our office? _____ _____

_____ _____ _____

Has your child received care for this problem before? _____ _____

When did the problem start? _____ How did the problem start? ___Suddenly ___Gradually ___Post-Injury

Is this condition: ___Getting Worse ___Improving ___Intermittent ___Constant ___Unsure

What makes the problem better? _____ _____

What makes the problem worse? _____ _____

Medications: What Medications is your child currently taking and for what conditions?_____

_____ _____ _____

HAS YOUR CHILD EVER SUFFERED FROM:

□ Headaches	□ Orthopedic Problems	□ Digestive Disorders	□ Behavioral Problems
□ Dizziness	□ Neck Problems	□ Poor Appetite	□ ADD/ADHD
□ Fainting	□ Arm Problems	□ Stomach Aches	□ Ruptures/Hernia
□ Seizures/Convulsions	□ Leg Problems	□ Reflux	□ Muscle Pain
□ Heart Trouble	□ Joint Problems	□ Constipation	□ Growing Pains
□ Chronic Earaches	□ Backaches	□ Diarrhea	□ Allergies to_____
□ Sinus Trouble	□ Poor Posture	□ Hypertension	□ Allergies to_____
□ Asthma	□ Scoliosis	□ Anemia	□ Allergies to_____
□ Colds/Flu	□ Walking Trouble	□ Bed Wetting	□ Other: _____
□ Colic	□ Broken Bones	□ Sleeping Problems	□ Other: _____

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS:

□ Fall in baby walker	□ Fall from bed or couch	□ Fall off skateboard or skates
□ Fall from crib	□ Fall off swing	□ Fall off bicycle
□ Fall from high chair	□ Fall off slide	□ Fall down stairs
□ Fall from changing table	□ Fall off monkey bars	□ Other: _____

Has your child ever sustained an injury playing organized sports? _____ If yes; please explain_____

_____

Has your child ever sustained an injury in an auto accident? _____ if yes; please explain_____

_____

PREGNANCY HISTORY:

Third Trimester Presentation: _____Vertex _____Breech _____Transverse _____Face/Brow

Type of Birth: _____Normal Vaginal _____Forceps _____Cesarean _____Suction Cap or Vacuum

Location: _____Home _____Hospital _____Birthing Center _____Other: _____

Problems during Pregnancy:_____

Problems during Labor/Delivery: _____

Was there the presence of: _____Jaundice? (Yellow) _____Cyanosis? (Blue) _____Congenital Anomalies/Defects?

If yes, please explain_____

INFANT HISTORY:

Infant feeding: _____Breast _____Bottle If Bottle; which Formula? _____

Number of Hours sleep per night _____ Quality of Sleep: _____Good _____Fair _____Poor

List all **IMMUNIZATIONS** you child has had**:** _____

Has your child ever been treated at the emergency room? _____ If yes; please explain _____

Has your child ever been hospitalized? _____ If yes; please explain _____

Has your child ever had any Surgeries? _____ If yes; please explain _____

Is your child currently on any medication? _____ If yes; please list: _____

DID THE CHILD EVER SHOW A DELAY FOR ANY OF THE FOLLOWING:

Respond to sound_____ Follow an object with his/her eyes_____ Hold heel up_____

Sit Alone_____ Crawl_____ Stand_____ Walk alone_____

WHAT ARE YOUR GOALS?

IMMEDIATE:	SHORT TERM:	LONG TERM:

INFORMED CONSENT:

I understand that I am directly and fully responsible to TRU Health Family 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.

PATIENT FINANCIAL OBLIGATION AGREEMENT:

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits to be paid directly to TruHealth Family Chiropractic for services rendered. I authorize representatives of TruHealth Family Chiropractic to release pertinent medical information to my insurance company when requested or to facilitate a payment of a claim.

_____ _____

Parent or Legal Guardian's Signature Date