Welcome to our office. Please complete this form to tell us how we can help you today.

firstchiropracticcenter.com

Patient Number ________
(office use only)

Today's Date: ___________

Have you consulted a chiropractor before? ○ No ○ Yes

____
Whom may we thank for referring you? When? __________ If so, Whom? ________________

First Name	MI	Last Name	Birthdate	Age	Gender ○M ○ F

Address	City	State	Zip

Primary Language	Race	Ethnicity	Preferred Communication
○ English ○ Spanish ○ Other	○ White ○ Hispanic ○ African American ○ Native American ○ Other	○ Hispanic or Latino ○ NOT Hispanic or Latino	○ Cell Phone ○ Home Phone ○ Work Phone ○ E-mail

Pediatrician	Father's Name	Mother's Name

Person Responsible for Account	Relationship to Patient

Cell Phone	Home Phone	Work Phone

E-mail Address	Employer of Parents

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I have read and reviewed the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **I may request a copy of the Financial Policy at any time.**

Initials ____ **I authorize my insurance company or administrator to pay First Chiropractic Centers, PC directly for the Benefits otherwise payable to me under my current policy**

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

______________________________ ______________________________
Signature Date (MM/DD/YYYY)

On behalf of (print child's full name) ______________________________________

Patient Number ________
(office use only)

____
Patient Name

What can the doctor help your child with today?

____

PREGNANCY HISTORY

Duration of Pregnancy________________ Delivery at ☐ Home ☐ Hospital ☐ Other

Prenatal Healthcare: ☐ OB ☐ Supplements ________________

☐ Medications________________ ☐ Complications ________________

Prenatal Fitness ________________

BIRTH HISTORY

Delivery ☐ Natural ☐ Drug-induced ☐ Drug-assisted ☐ C-section-Planned ☐ C-section-Emergency

Labor ☐ < 3 Hrs. (precipitous) ☐ 3-6 Hrs. ☐ 3-6 Hrs. ☐ 6-15 Hrs. ☐ > 15 Hrs. (prolonged)

Complications ☐ Abnormal Birth Position ☐ Forceps Used ☐ Spinal Anesthesia ☐ Vacuum Extractor

Baby Length and Weight at Birth ________________APGAR Score________

EARLY CHILDHOOD HISTORY
(age or duration)

Crying, Irritability________________Recurrent Ear Infections________________

Falls ________________Nursing or Bottlefed________________

Medications________________Supplements________________

Surgery ________________

RECENT HEALTH HISTORY

Falls ________________Accidents ________________

Surgery ________________

Behavior At Home ________________

School Performance ________________

Eating Habits________________

Sleep Habits________________

____
Doctor's Initials

Patient Name:

Patient Number (office use):__________

Review of Systems

Please check beside any current or past concerns

- O Neck Problems
- O Back Problems
- O Joint Problems
- O Scoliosis
- O Swollen Joints
- O Arthritis
- O Anxiety/Depression
- O Weakness
- O Headache/Migraines
- O Dizziness
- O Numbness/Tingling
- O High Cholesterol
- O High Blood Pressure
- O Asthma
- O Seasonal Allergies
- O Shortness of Breath
- O Emphysema or COPD
- O Abdominal Pain
- O Kidney Stones
- O Constipation
- O Diarrhea

Past Medical History

Illnesses

- O Diabetes
- O Cancer
- O Epilepsy
- O Multiple Sclerosis
- O Stroke
- O Heart Disease
- O Shingles
- O Other ____________
- O None

Operations

- O Cardiovascular Surgery
- O Cancer
- O Other ____________
- O None

Family History

- O Stroke
- O Cancer
- O Cardiovascular Disease
- O Diabetes
- O Other ____________
- O None

Social History

Exercise

- O Daily
- O Weekly
- O Never/Not Much at All

Tobacco Use

- O None
- O Smoke
- O Smokeless

List Prescription Medications (We can happily make a copy of your list instead of writing here)

____

____

____

List Vitamins and Supplements

____

____

____

Is there anything else we should know?

____

____

____