MONTROSE
FAMILY CHIROPRACTIC

Montrose Family Chiropractic
145 Nelson Blvd suite 1000
Po box 406, Montrose, MN 55363
763-330-2302

Children ages 0-6 years old

Patient name: _____ **Date of birth:** _____
Last first middle initial

Address: _____
Street Address po box city state zip code

Phone: _____ _____
Home phone Cell phone

Email address: _____

Sex: Male Female

Emergency Contact: _____ **Phone Number:** _____

Do you have health insurance? **Yes** (fill out next section) **No** (skip next section)

_____ _____ _____ _____ _____
Primary Insurance Name, **Address of Insurance,** **City** **State** **Zip Code**

Ave you the primary name on this Insurance Policy? **Yes** **No**

If no, then who is? _____ _____ _____ _____ _____
Last name First Name SSN Date of birth Relationship to insured

Policy/ID Number: _____ **Group Number:** _____

_____ _____ _____ _____ _____
Secondary Insurance Name, **Address of Insurance,** **City** **State** **Zip Code**

Ave you the primary name on this Insurance Policy? **Yes** **No**

If no, then who is? _____ _____ _____ _____ _____
Last name First Name SSN Date of birth Relationship to insured

Policy/ID Number: _____ **Group Number:** _____

I authorize the release of any medical or other information to Montrose Family Chiropractic as necessary to process this claim. I also request payment of medical benefits from either a government or non-government source to Montrose Family Chiropractic. I authorize Montrose Family Chiropractic to initiate a complaint to the Insurance Commissioner on my behalf. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered, and I understand that I will be charged 1.5% monthly or (18% annual percentage rate) with a minimum monthly fee of $1.00, on any non-contract insurance balances over 30 days. I further understand that I will be legally responsible for all collection costs involved with the collection of this account including all court costs, reasonable attorney fees and all other expenses incurred with collection if I default on this agreement. In addition, if I issue a check that is returned by the bank for non-sufficient funds, I understand I will be charged for $40.00 for each returned check. While Montrose Family Chiropractic will aide in the processing of my non-contract insurance claim, I understand that if my insurance does not pay within 60 days, my account will be determined as self-pay and due in full by myself. I certify this information is true and correct to the best of my knowledge.

Signature: _____ **Date:** _____

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Children's Health Review

Patient's Name _____ **Date** _____

Parents' (Legal Guardians') Names: _____ _____
Mother's Name Father's Name

Family Doctor/Pediatrician's Name: _____

Date of last visit: _____ Reason: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your child's care at this office? _____

How was your child referred to Montrose Chiropractic Clinic? _____

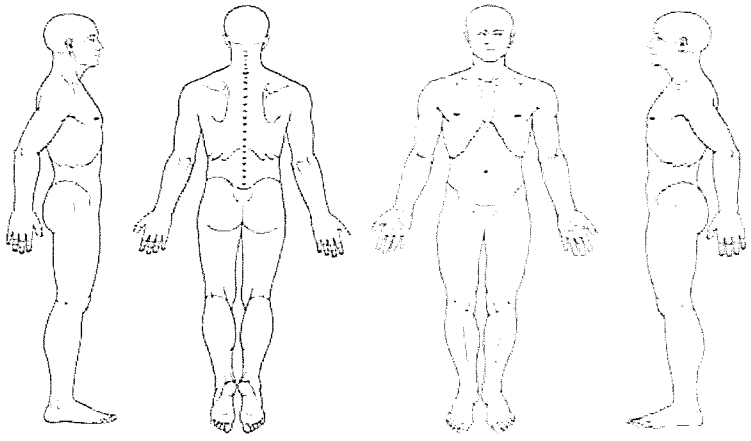
Has your child seen another Chiropractor before? ☐ Yes ☐ No
If so, when: _____ For what Condition: _____

Please describe the problem that brings your child to our office: _____

_____

_____

Please indicate the problem areas on the diagram:



Has the child ever had similar symptoms in the past?
☐ Yes ☐ No

When did the problem begin? _____

What caused the pain or trouble? _____

_____

_____

How are the symptoms changing?
☐ getting better ☐ not changing ☐ getting worse

What makes the pain/trouble worse? _____

What makes the pain/trouble better? _____

How often does the child experience the symptoms? ☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Describe any treatments they have received for this problem: _____

_____

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Children's Health Review

1.) Date of last general physical examination: _____ ☐ never had one

2.) Date of last spinal examination: _____ ☐ never had one

3.) Does your child take vitamin supplements? ☐ No ☐ Yes, please list: _____

4.) Does your child take any medications? ☐ No ☐ Yes, please list: _____

5.) Were there any complications at birth? ☐ No ☐ Yes, please list: _____
Was the forceps necessary? ☐ No ☐ Yes
Was the use of any medication necessary for the mother? ☐ No ☐ Yes

6.) Is there any indication of visual problems? ☐ No ☐ Yes

7.) Is there any indication of hearing problems? ☐ No ☐ Yes

8.) Any variance from normal developmental? ☐ No ☐ Yes

9.) Did this child ever use a walker or Johnny-jump-up? ☐ No ☐ Yes, for how long? _____

10.) Have there ever been any known injuries? ☐ No ☐ Yes, please list: _____

11.) Is/was your child breast fed? ☐ No ☐ Yes

12.) Are/were there any dietary problems? ☐ No ☐ Yes, please list: _____

13.) Does your child eat a lot of sweets, food with
Coloring, junk food, or processed food? ☐ No ☐ Yes
How much water do they consume in a day? _____

14.) Is there any indication of food (or other) allergies? ☐ No ☐ Yes, please list: _____

15.) Is there any indication of ongoing constipation or
Diarrhea or other digestive complaints? ☐ No ☐ Yes, please describe: _____

16.) Does your child sleep poorly? ☐ No ☐ Yes, please describe: _____

17.) Is there any problem with enuresis (bed wetting)? ☐ No ☐ Yes
Is your child continent through the day? ☐ No ☐ Yes

18.) If in school, is there any problem with:
Attention span? ☐ No ☐ Yes
Physical coordination? ☐ No ☐ Yes
Sitting still? ☐ No ☐ Yes
Interaction with other children? ☐ No ☐ Yes

19.) What does your child prefer to be: ☐ active (i.e. sports, games) ☐ inactive (i.e. reading, puzzles?)

20.) Is there any indication of ongoing or frequent colds, ear infections, asthma, or bronchitis? ☐ No ☐ Yes

21.) Is there any complaint of spinal problems? ☐ No ☐ Yes, please describe: _____

22.) Is there any complaint of joint problems? ☐ No ☐ Yes, please describe: _____

23.) Does your child have brothers and sisters? ☐ No ☐ Yes, please list: _____

24.) Do any of your child's siblings have any health problems? ☐ No ☐ Yes, please list: _____

Parent/Patient Signature: (or legal guardian) _____ **Date:** _____

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Infant Functional Form (ages 0-1)

Today's date: _____

Child's name: _____

Please check all that apply to your child:

1. _____ Has your child been more irritable/less consolable?
2. _____ Has your child had difficulty sleeping?
3. _____ Has your child's sleeping pattern changed?
4. _____ Has your child's digestion pattern changed? (ex. Constipation/diarrhea)
5. _____ Has your child's intake of food been more or less?
6. _____ Has your child needed more parental attention-affection?
7. _____ Has your child been more distant/less affectionate?
8. _____ Has your child had trouble with nursing or taking a bottle?
9. _____ Has your child had a developmental milestone and then lost it? (ex. Able to roll over and no longer can do so.)
10. _____ Has your child shown unwarranted emotions such as fear?
11. _____ Has your child shown a new physical issue for comfort? (ex. Sucking their thumb or blanket.)
12. _____ Has a normal daily activity shown change? (ex. Cries not when put in car seat.)
13. _____ Have any normal play patterns changed?
14. _____ Have you noticed any changes in relationships with grandparents/daycare providers?

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Pediatric Functional Form (ages 2-6)

Today's Date: _____

Childs name: _____

Please check all that apply to your child:

1. _____ Has your child had difficulty sleeping?
2. _____ Have your child's sleeping patterns changed?
3. _____ Has your child's digestion pattern changed? (ex. Constipation/diarrhea)
4. _____ Has your child's intake of food been more or less?
5. _____ Has your child needed more parental attention/affection?
6. _____ Has your child been more distant/less affectionate?
7. _____ Has your child had trouble with learning or retaining information?
8. _____ Has your child balance coordination been altered?
9. _____ Has your child's attention or focus been shortened?
10. _____ Have you noticed any changes in speech patterns?
11. _____ Have you noticed any changes in breathing patterns?
12. _____ Have you noticed any visional changes such as squinting?
13. _____ Have you noticed any playing patterns?
14. _____ Have you noticed any aggression/violence/acting out?
15. _____ Have you noticed any changes in relationships with grandparents/daycare providers?