Child Patient Information

Child's Name:_____ Date:_____ File#:_____

Date of Birth:_____ Age:_____ Sex: □Male □Female Number of Siblings:_____

Mother's Name:_____ Phone:_____ □Home □Work □Cell

Father's Name:_____ Phone:_____ □Home □Work □Cell

Address:_____ City:_____ State:_____ Zip:_____

Who referred you to our office?_____

Purpose of this appointment:_____

When did this problem begin:_____ Is this problem getting worse: □Yes □ No

Is this problem: □Constant □Comes & Goes Has the child had this complaint before? □Yes □ No

Is this problem worse during a certain part of the day?_____

Does this interfere with child's: □Sleep □Eating □Daily Routine □Other_____

What makes it better:_____ What makes it worse:_____

Other Doctor's Seen for this Condition:_____

Prior Treatments:_____

We are here to provide you and your family with the best care possible and answer any questions you may have.
Thank you for trusting us with the care of your child.

Authorized For Care of Minor

I hereby authorize this office and its doctor(s) to administer care as they so deem, necessary to my Son/daughter/ward (upon approval of parent or guardian).

Signed:_____ Print Name:_____ Date:_____

I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided. X-rays remain the property of this office.

Signed:_____ Date:_____

Circle any of the Following Conditions Your Child has suffered from During the Past Six Months:

Scoliosis	Frequent Colds	Ear Infections	Neck/Back Pain	Behavior Problems
Asthma /Allergies	Headaches	Bed Wetting	Sports Injury	ADD/ADHD
Digestive Problems	Constipation	Growing Pains	Diabetes	Other _____

Circle any of the following spinal traumas this child has suffered from:

Fall from crib	Fall from bed or couch	Fall off slide	Fall off swing	Fall off skateboard or skates
Fall from highchair	Fall off monkey bars	Fall off bicycle	Fall down stairs	Other:_____

Pediatrician/Family MD:_____

Date of Last Visit:_____ Purpose:_____

Number of Doses of Antibiotics Your Child Had Taken: In Past Six Months_____ In Lifetime_____

Has this child ever been treated on an emergency basis?_____

Has this child ever sustained an injury playing organized sports?_____

Has this child ever sustained injuries in an auto accident?_____

Other Accidents?_____

Surgery:_____

Medications:_____

Family History:_____

Complications during pregnancy, labor or delivery:_____

_____

Is there anything else you feel we should know:_____

_____

Chiropractic adjustments insure your brain is communicating with every organ in your body and therefore is an important part of health and wellness. Did you know chiropractic can improve your immune system, help with frequent colds, bed wetting, ensure top athletic performance and many other aspects of a healthy body. If you want to know if chiropractic can help with anything in particular just ask us.