

PATIENT DEMOGRAPHICS

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	AGE:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SOCIAL SECURITY NUMBER:
BIRTH HEIGHT:	BIRTH WEIGHT:
RACE: <input type="checkbox"/> AMERICAN INDIAN or ALASKA NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK or AFRICAN AMERICAN <input type="checkbox"/> WHITE (CAUCASIAN) <input type="checkbox"/> OTHER <input type="checkbox"/> I DECLINE TO ANSWER	
ETHNICITY: <input type="checkbox"/> HISPANIC or LATINO <input type="checkbox"/> NOT HISPANIC OR LATINO <input type="checkbox"/> I DECLINE TO ANSWER	
MOTHER'S NAME:	
MOTHER'S DATE OF BIRTH:	MOTHER'S CELL PHONE:
FATHER'S NAME:	
FATHER'S DATE OF BIRTH:	FATHER'S CELL PHONE:
WHO IS RESPONSIBLE FOR PAYMENT:	
RESPONSIBLE PAYOR'S SOCIAL SECURITY NUMBER:	
DO YOU HAVE HEALTH INSURANCE: <input type="checkbox"/> YES <input type="checkbox"/> NO	

SUPPLEMENTS AND MEDICATIONS

LIST PRESCRIPTION AND NON-PRESCRIPTION DRUGS YOUR CHILD TAKES:
DOES YOUR CHILD HAVE ANY MEDICATION ALLERGIES? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES WHAT MEDICATION AND REACTION:
LIST VITAMINS AND SUPPLEMENTS YOUR CHILD TAKES:

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HOW HAVE YOU SEEN OR HEARD OF OUR OFFICE (✓ ALL THAT APPLY) <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> INTERNET <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE: <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:

HISTORY OF COMPLAINT

PURPOSE OF THIS VISIT: <input type="checkbox"/> WELLNESS CHECK-UP <input type="checkbox"/> INJURY or ACCIDENT <input type="checkbox"/> OTHER	
PLEASE EXPLAIN:	
IS YOUR CHILD EXPERIENCING PAIN/DISCOMFORT? IF YES WHERE/HOW LONG:	
WHEN DID PROBLEM FIRST BEGIN: DATE ___/___/___ <input type="checkbox"/> UNKNOWN <input type="checkbox"/> GRADUAL <input type="checkbox"/> SUDDEN	EVER HAD THIS PROBLEM BEFORE: <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, WHEN?
ANY BOWL OR BLADDER PROBLEMS SINCE THIS PROBLEM BEGAN: <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, DESCRIBE:	
HAS YOUR CHILD SEEN ANY OTHER DOCTORS FOR THIS PROBLEM: <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, WHO: _____	
HOW LONG AGO: ___ DAYS ___ WEEKS ___ MONTHS ___ YEARS	
WHAT WERE THE RESULTS OF PAST TREATMENT:	
HOW IS THIS PROBLEM NOW: <input type="checkbox"/> ON & OFF <input type="checkbox"/> RAPIDLY IMPROVING <input type="checkbox"/> IMPROVING SLOWLY <input type="checkbox"/> ABOUT THE SAME <input type="checkbox"/> GRADUALLY WORSENING	
PLEASE LIST ANY MEDICATION TAKEN FOR THIS PROBLEM:	
HAS YOUR CHILD EVER BEEN INJURED PLAYING ORGANIZED SPORTS: <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, PLEASE EXPLAIN: _____	
HAS YOUR CHILD EVER BEEN INJURED IN AN AUTO ACCIDENT: <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, PLEASE EXPLAIN: _____	



PAST HISTORY

HAS YOUR CHILD EVER SUFFERED FROM: *CHECK ALL THAT APPLY*

- | | | |
|--|---|---|
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> NECK PROBLEMS |
| <input type="checkbox"/> POOR APPETITE | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> FAINTING |
| <input type="checkbox"/> ARM PROBLEMS | <input type="checkbox"/> STOMACH ACHES | <input type="checkbox"/> RUPTURES/HERNIA |
| <input type="checkbox"/> LEG PROBLEMS | <input type="checkbox"/> REFLUX | <input type="checkbox"/> MUSCLE PAIN |
| <input type="checkbox"/> JOINT PROBLEMS | <input type="checkbox"/> HEART TROUBLE | <input type="checkbox"/> CONSTIPATION |
| <input type="checkbox"/> GROWING PAINS | <input type="checkbox"/> CHRONIC EARACHES | <input type="checkbox"/> BACKACHES |
| <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> SINUS TROUBLE |
| <input type="checkbox"/> POOR POSTURE | <input type="checkbox"/> HYPERTENSION | <input type="checkbox"/> WALKING TROUBLE |
| <input type="checkbox"/> SCOLIOSIS | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> COLDS/FLU |
| <input type="checkbox"/> SLEEPING PROBLEMS | <input type="checkbox"/> BED WETTING | <input type="checkbox"/> COLIC |
| <input type="checkbox"/> BROKEN BONES | <input type="checkbox"/> DIGESTIVE DISORDERS | <input type="checkbox"/> BEHAVIORAL PROBLEMS |
| <input type="checkbox"/> ORTHOPEDIC | <input type="checkbox"/> SEIZURES/ | <input type="checkbox"/> FALL OFF SWING |
| <input type="checkbox"/> FALL IN BABY WALKER | <input type="checkbox"/> FALL FROM BED OR COUCH | <input type="checkbox"/> FALL FROM CRIB |
| <input type="checkbox"/> FALL DOWN STAIRS | <input type="checkbox"/> FALL OFF BICYCLE | <input type="checkbox"/> FALL FROM HIGH CHAIR |
| <input type="checkbox"/> FALL OFF SKATEBOARD/ SKATES | <input type="checkbox"/> FALL FROM CHANGING TABLE | <input type="checkbox"/> FALL OFF MONKEY BARS |
| <input type="checkbox"/> FALL OFF SLIDE | <input type="checkbox"/> OTHER _____ | |
| <input type="checkbox"/> ALLERGIES TO _____ | | |

FAMILY HISTORY

DOES ANYONE IN YOUR FAMILY SUFFER WITH THE SAME CONDITION(S)?

- NO YES **IF YES WHOM:** GRANDMOTHER GRANDFATHER
 MOTHER FATHER SISTER(S) BROTHER(S) SON(S)
 DAUGHTER(S)

HAVE THEY EVER BEEN TREATED FOR THEIR CONDITION?

- NO YES I DON'T KNOW

ANY OTHER HEREDITARY CONDITIONS THE DOCTOR SHOULD BE AWARE OF? NO YES:

IF YES, DESCRIBE:

For office use only

Height: _____ Weight: _____

Blood Pressure: _____/_____

INFORMED CONSENT

I UNDERSTAND THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO FULL POTENTIAL 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.

PARENT OR LEGAL GUARDIAN'S SIGNATURE

_____/_____/_____
DATE

DOCTOR'S SIGNATURE

_____/_____/_____
DATE

MEDICAL INFORMATION RELEASE FORM (HIPAA)

NAME: _____ DATE OF BIRTH: ____/____/____

RELEASE OF INFORMATION:

I authorize the release of information including the diagnosis, records; examination rendered to my child and claims information. This information may be released to:

Name _____ Relationship _____

Information is not to be released to anyone

This **Release of Information** will remain in effect until terminated by me in writing.

PARENT OR LEGAL GUARDIAN'S SIGNATURE

_____/_____/_____
Date Witness Initials

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

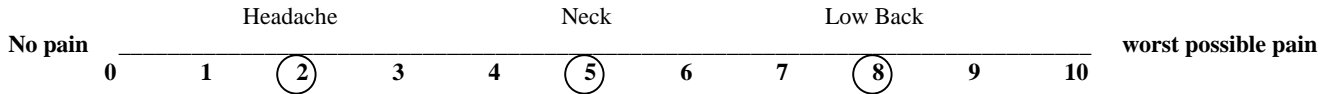
Date _____

Please read carefully:

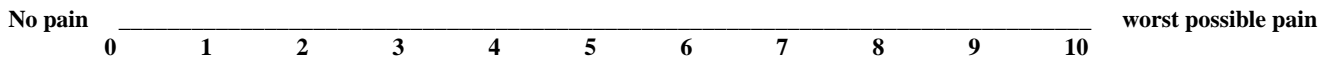
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

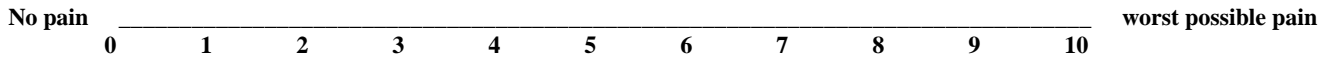
Example:



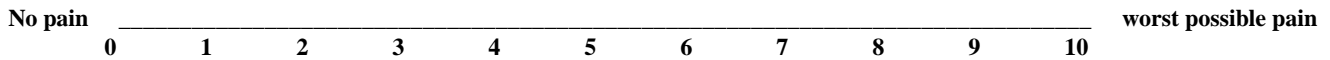
1 – What is your pain RIGHT NOW?



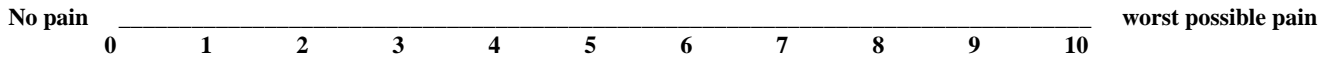
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

Examiner _____

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