Short BACK TO HEALTH Chiropractic

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Patient Information

Child Name ____________________________________ Parent(s)/ Guardian Name __________________________________

Address ______________________________________ City ___________________ State __________________ Zip ________

Home Phone _______________________ Work Phone ________________________ Cell Phone _______________________

Is it okay to contact you at work? Yes No

Email __________________________ Child's Social Security # _________________ Birthday _______________ Age ______

Have you or your child ever had chiropractic care before? Yes No

If yes, please tell us the doctor's name ____

Were you pleased with your care? Yes No

How did you find out about our office? ____

Is this appointment related to auto accident? Yes No

Is your child receiving care from other health Professionals? Yes No

If yes, please name them and their specialty ____

Who is your family's primary care physician? ____

Please list any drugs or medications your child is taking ____

Please list any vitamins/herbs/homeopathic/other your child is taking ____

Please list any allergies your child has ____

CURRENT HEALTH

What health conditions bring your child to our office? ____

____

When did the symptoms first begin? ____

How did the problem start? Suddenly Gradually Post-injury

Is this condition Getting worse Improving Intermittent Not sure?

What makes the problem better? ____

What makes the problem worse? ____

Has your child ever had a similar condition? Yes No

Please explain: ____

Has your child been treated for this problem before: Yes No

Please explain: ____

Does your child eat well? Yes No Does your child have regular bowel/ bladder movements? Yes No

Has your child ever been checked for vertebral subluxations? Yes No Don't know

HEALTH HISTORY

Child's birth was: At home At a birthing center At a hospital

My obstetrician/midwife/family physician was ____

Child's Birth was Natural vaginal (no medications/interventions)

Vaginal with interventions

Induction Pain medications Epidural Episiotomy Vacuum Extraction Forceps

Other ____

C-Section

Scheduled Emergency

Please list reasons for any interventions/complications ____

____

Child's birth weight ___________ Child's Birth height ___________ Current weight ___________ Current height ______

APGAR score at birth _____________ APGAR score after 5 minutes

GROWTH & DEVELOPMENT

Was your child alert and responsive within 12 hours of delivery? Yes No

If no, please explain ____

At what age did the child:

Respond to sound ___________ Follow an object _____________ Hold head up ___________ Vocalize _______

Sit alone _____________ Teethe ______________ Crawl _____________ Walk _____________

Patient/Hospitalization/Surgical history (please list below all surgeries and Hospitalizations, including the year)

____

____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year ____

____

Is/was your child breastfed? Yes No If yes, how long? _________________

Formula introduced at age _______________ What type? ____________________________________

Introduction of cow's milk at age ______________________ Began solid food at age ________________________

Please list any food/juice intolerance ____

Did Mother smoke during pregnancy? Yes No Did Mother drink alcohol during pregnancy? Yes No

Any illness of Mother during pregnancy? Yes No

If yes, Please explain including treatment/medications/supplements ____

____

List any drugs/medications (including over the counter) taken during pregnancy ____

____

List any supplements taken during pregnancy ____

Any exposures to ultrasound? Yes No If so, how many and what was the medical reason? __________

____

Any pets at home? Yes No Any smokers at home? Yes No

Has your child received any vaccinations? Yes No If yes, which ones and list any reactions _____________

____

Has your child received any antibiotics? Yes No If yes, please explain _____________________________

____

Any difficulty with breastfeeding? Yes No If yes, please explain ___________________________________

____

Any difficulty with bonding? Yes No If yes, please explain ____

____

Any behavioral problems? Yes No If yes, please explain ____

____

Any night terrors, sleepwalking or difficulty sleeping? Yes No If yes, please explain_______________________

____

Age your child began daycare ____________________ Average number of hours of TV per week ________________

Does your child seem normal for their age? Yes No If no, please explain______________________________

____

FAMILY HISTORY REVIEW

Check those involved immediate family and add identification *M=Mother, F=Father, S=Siblings, G=Grandparents*

Cancer Type ___________ *M F S G*	Depression *M F S G*	Diabetes *M F S G*	Back Problems *M F S G*
Heart Disease *M F S G*	Liver Disease *M F S G*	High Blood Pressure *M F S G*	High Cholesterol *M F S G*
Lung Problems *M F S G*	Scoliosis *M F S G*	Neck Problems *M F S G*	Osteoporosis *M F S G*
Seizures *M F S G*	Osteoarthritis *M F S G*	Rheumatoid Arthritis *M F S G*	

Other ____

____

DO YOU KNOW ABOUT CHIROPRACTIC?

Do you know what a subluxation is? Yes No Do any of your friends or relatives see a chiropractor? Yes No

If yes, do they use chiropractic for: Health maintenance/optimization Health problems Both

Are you seeking chiropractic for: Health maintenance/optimization Health problems Both

What would you like to gain from chiropractic care? ____

____

Are there other health concerns or anything else you'd like us to know about your child? ___________________________

____

INSURANCE COVERAGE INFORMATION

PRIMARY INSURANCE:

Insurance Carrier ____ Phone _____________________________

Policy Holder Name _______________________________ Policy Number __________________ Group Number _________

Insured Date of Birth _______ Insured Home # _______ Insured Work # _______ Relationship __Spouse __Child __Other

SECONDARY INSURANCE:

Insurance Carrier ____ Phone _____________________________

Policy Holder Name _______________________________ Policy Number __________________ Group Number _________

Insured Date of Birth _______ Insured Home # _______ Insured Work # _______ Relationship __Spouse __Child __Other

Auto/Personal Injury: Do you have "Med Pay" on your Auto Policy: Yes No Amount $ ________________

TREATMENT OF MINOR: (Must be signed by parent or legal guardian if patient is a minor under age 18); I hereby authorize Short Chiropractic Inc. and its assistants to administer chiropractic care as deemed necessary to my ________.

(Relationship)

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement. I hereby authorize and direct my medical benefits to be paid to Short Chiropractic Inc. and agree that I am financially responsible for non-covered services or items. I hereby give permission to Short Chiropractic Inc. to administer treatment and perform such general procedures as the doctor may deem necessary in the diagnosis and/or treatment for my condition.

Patient's Signature: ____ Date: ____________________________

Parent or Guardian: ____ Date: ____________________________