CONFIDENTIAL PATIENT INFORMATION (CHILD)

Dear Parent, ***Please read and complete this questionnaire in detail****. Your answers will help us determine if chiropractic can assist your child. If we do not seriously believe your condition will respond satisfactorily, we will not accept his/her case.*

Childs Name: First _____MI _____Last _____Age: _____
Address: _____City: _____State: _____Zip: _____
Parent (s)/Guardian(s): _____
Home Phone: _____ Work Phone: _____ DOB: _____
Occupation: _____ Employer: _____
Siblings Name(s) & Age(s): _____
_____
Most patients are referred to our office by a caring family member or friend. Who may we thank for referring you to our office? _____

Insurance Information

If you are insured and wish for us to assist you in submitting your claims, please provide us with your insurance card so that we may make a copy and verify your coverage in this office.

ADDRESSING THE ISSUES THAT BROUGHT YOUR CHILD TO THE OFFICE

Briefly describe the chief area of complaint, including the effect it has had on your child's life. _____
_____
_____
Since the problem started, is it … About the same Getting better Getting worse
What makes it worse? _____
Yes, it interferes with: Sleep Walking Sitting Hobbies Play
Does he/she suffer from any condition other than that which you are now consulting us? Yes / No Please explain._____
_____
When did this problem first appear? _____Has he/she experienced this in the past? Yes / No
Doctors seen for this problem: Chiropractor(s) _____ Medical Doctor(s) _____
Has anyone in your family experienced similar problems? Y / N If so, who? _____

Prescription medications may cause various side effects, hide the severity of health conditions and or hinder the body's ability to heal. What medications is your child currently taking? _____
_____
Has your child ever been knocked unconscious? Y / N Explain:_____

BODY SIGNALS

Please circle **ALL** symptoms (body signals) your child has ever had, even if they do not seem related to the current problem.

Headaches	Pins and needles in legs	Fainting	Neck pain
Pins and needles in arms	Colds	Back pain	Loss of balance
Dizziness	Buzzing in the ears	Ear Infections	Nervousness
Numbness in fingers	Numbness in toes	Loss of taste	Stomach upset
Fatigue	Depression	Irritability	Tension
Sleeping problems	Neck stiff	Bronchitis	Asthma
Diarrhea	Constipation	Fever	Continence
Cold sweats	Lights bother eyes	Enuresis (Bed wetting)	Heartburn
Mood swings	Allergies	Ulcers	Colic

Poor posture leads to poor health and often indicates a spinal condition.
How would you rate your child's posture? Poor – 1 2 3 4 5 6 7 8 9 10 – Excellent

Patient's/Guardian's Signature: X _____Date: _____

CHIROPRACTIC*USA*

AUTHORIZATION
TREATMENT OF A MINOR

Date:_____

Minor Name:_____

Date of Birth:_____Social Security Number: #_____

As the parent / legal guardian of the above minor, I hereby authorize the Doctor(s) of Chiropractic*USA* and whomever they may designate as their assistants to administer Chiropractic Care and Physical Rehabilitation for _____ as he / she deems appropriate.

Name (print):_____

Name (sign):_____

Relationship to minor:_____

Witness:_____