PRECISION CHIROPRACTIC

MINOR CONFIDENTIAL HEALTH INFORMATION

PATIENT INFORMATION *all fields required*

First Name:_____ Middle Initial:_____ Last Name: _____

Name you go by: _____ Date of Birth: _____ Age: _____ Last 4 of social: xxx-xx-_____

Best Contact Information regarding appointments:
Parent/Guardian's Name: _____ Email: _____

Phone:_____ Address:_____ City: _____ State:_____

Who is responsible for this account: ☐ Same as above ☐ Other: Name: _____

Phone:_____ Address:_____ City:_____ State:_____

Relationship to Patient: _____

PURPOSE OF VISIT

☐ Wellness assessment(no symptoms) ☐ Evaluation of the following symptoms (circle below):

Circle All that apply:

ADD/ADHD	Asthma	Accident/Injury
Headaches	Sinus/Allergies	Muscle Aches/Pains
Autism	Colds/Fevers	Scoliosis
Anxiety	Ear Infections	Other: _____

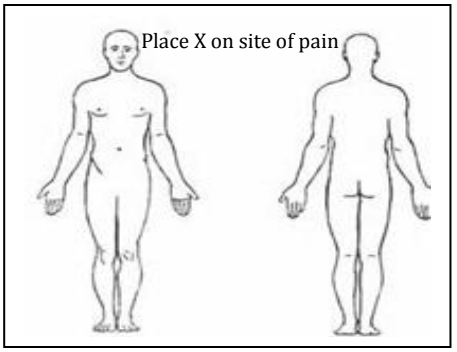
PATIENT CONDITION

Reason for Visit_____
Is this due to an accident or injury? ☐ Yes ☐ No

Is your condition getting worse? ☐Yes ☐No Has your condition been treated in the past by a doctor? ☐ Yes ☐ No

How long have you had the above problems? (If accident or injury, write date)_____

How often do you have the above problems?(Choose one)
☐ Weekly ☐ 25% of day ☐ 50% of day ☐75% of day ☐Constant/Daily



Rate your pain intensity from (circle) *None* 1 2 3 4 5 6 7 8 9 10 Severe

Describe your pain: ☐ sharp ☐ dull ☐ throbbing ☐burning ☐ numb ☐ achy ☐ tingling ☐ radiating

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HEALTH HISTORY

PLEASE CHECK ANY AND ALL PROBLEMS YOU HAVE HAD IN THE LAST 2 YEARS:

- ☐ Dizziness
- ☐ Diabetes
- ☐ Colds/Flu
- ☐ Headaches
- ☐ Orthopedic Problems
- ☐ Behavioral Problems
- ☐ Growing Pains
- ☐ Backaches
- ☐ Tuberculosis
- ☐ Allergies
- ☐ Digestive Disorder
- ☐ Diarrhea
- ☐ Bed Wetting
- ☐ Stomach Aches
- ☐ Heart Condition
- ☐ Hyptertension
- ☐ Asthma
- ☐ Constipation
- ☐ Hyperactivity
- ☐ Broken Bones
- ☐ Other_____

List Medications

_____ _____ _____

_____ _____ _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child? ____N ____Y

Is / has your child been involved in any high impact or contact type sports? ___N ___Y Type:_____

Has your child ever been involved in a car accident? ___N ___Y Date:_____

Has your child been seen on an emergency basis? ___N ___Y Reason and Date:_____

Other traumas not described above? ___N ___Y Date:_____

Complications during delivery: ____N ____Y List: _____

SOCIAL HISTORY

- Which of the following sports have you been involved in? ☐Football ☐Ski / Snowboard ☐Soccer ☐Running ☐Gymnastics/Cheerleading ☐Martial Arts ☐Horseback riding ☐Other; _____
- Have you ever… ☐ Fallen down the stairs ☐Slipped/Fell on the ground (or ice) ☐Had a sports injury ☐ Broken a bone if so, which one? _____

CHIROPRACTIC HISTORY

Research shows that your spine should be checked regularly. When did you last see a chiropractor? _____
Reason for care: _____ Favorable outcomes? Yes / No Did you follow recommendations? Yes / No
Who else in your family is under chiropractic care? _____

RELEASE OF CARE

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

_____ _____

Signature Date