

PATIENT INFORMATION *all fields required*

First Name: _____ Middle Initial: _____ Last Name: _____
 Name you go by: _____ Date of Birth: _____ Age: _____ Gender: _____
 Parent/Guardian's Name: _____ Relationship to Patient: _____
 Phone: _____ Email: _____
 Street Address: _____ City: _____ State: _____ Zip: _____

PATIENT CONDITION

Reason for Visit _____ OR Wellness Assessment (no current symptoms)
 Is this due to an accident or injury? Yes No Type of Accident: Auto Home Other: _____
 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
 What makes your condition better? _____ worse? _____

HEALTH HISTORY

Please check all that apply:

- | | | | | |
|--------------------------------------|---|---------------------------------------|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Torticollis | <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Orthopedic Injury | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Eczema | <input type="checkbox"/> Constipation | <input type="checkbox"/> Digestive Issues | <input type="checkbox"/> Trouble Sleeping |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Asthma | <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Developmental Delays |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Growing Pains | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Autism | <input type="checkbox"/> Menstrual Issues |
| <input type="checkbox"/> Other _____ | | | | |

List Medications:

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 payments of all fees charged by this office unless other arrangements have been made.

 Minor Name

 Date

 Parent/Guardian Name Printed

 Signature