BEARD CHIROPRACTIC FAMILY WELLNESS CLINIC

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3 – 12 YEARS CONFIDENTIAL PATIENT INFORMATION

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

Today's Date:_____

PATIENT INFORMATION:

Child's Name:_____Child'sNickname:_____

Child's Address and Phone (if different from yours):_____

Reason for visit:_____

Sex: M / F Birthdate:_____ Age:_____ Who may we thank for referring you?_____

FAMILY INFORMATION:

Mother's Name:_____ Father's Name: _____

Address:_____ Address: _____

Home & Work Phone:_____ Home & Work Phone_____

Parents Marital Status: Mar ____ Sing ____ Div ____ Wid ____ Main language at home:_____

List ages of other children in family:_____

PAYMENT INFORMATION:

Please read and sign our Financial Agreement. Does your health insurance cover chiropractic? Y / N

If you have insurance that may cover chiropractic services, please provide you current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for the child's health insurance coverage.
Insured's Name:_____Birth Date:_____ SSN:_____

Insurance Company: _____Phone No.:_____

Employer: _____Group#: _____ Insured's ID:_____

CONSENT TO TREAT:

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son / daughter named _____ as the examining / treating doctor deems necessary.

I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Parent's Name Printed:_____Signature:_____

Date: _____Witnessed by:_____

Please answer the following questions:

Reason for today's visit: _____

When did this problem first occur? _____

Yes No

☐ ☐ **Has your child ever had this problem before? Explain:**_____

☐ ☐ **Has s/he previously been treated for this problem? Doctor's name:**_____

☐ ☐ **Has s/he previously been to a chiropractor? When?**_____

What sports does your child play?_____

HEALTH HISTORY:

Use lines to explain any "yes" answers ⇩

Yes No

☐ ☐ **Does your child ever complain of back or neck pain?** _____

☐ ☐ **Does your child ever complain of pains in the legs or arms?**_____

☐ ☐ **Does your child ever complain of headaches?** _____

☐ ☐ **Does your child have a problem with bedwetting?** _____

☐ ☐ **Has your child had asthma?**_____

☐ ☐ **Is your child allergic to anything?** _____

☐ ☐ **Are there any smokers in the child's home?** _____

☐ ☐ **Has your child had any earaches? At what age did the child's first earache occur?** _____

How frequently does you child have earaches? _____

In which ear do your child's earaches usually occur? Right ☐ **Left** ☐ **Both** ☐

Please list any other illness which have been a concern for your child:_____

Please list any surgeries your child has had : _____

☐ ☐ **Are there any other concerns about your child's health:** _____

TRAUMA:

⇩

Yes No

☐ ☐ **Has your child had any recent falls or trauma:** _____

Describe the trauma and the date it occurred: _____

☐ ☐ **Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar items?**_____

☐ ☐ **Has your child ever fallen down stairs or fallen from a significant height?** _____

☐ ☐ **Has your child ever been in a motor vehicle collision or near-miss? _____**

☐ ☐ **Has your child ever had a bone fracture or joint dislocation? _____**

☐ ☐ **Has your child had any other trauma or injuries? _____**

☐ ☐ **Does your child ever bang his / her head repeatedly against a wall, bed or other object? _____**

NUTRITION:

Yes No

☐ ☐ **Do you have any concerns about your child's diet? _____**

☐ ☐ **Does your child have any food allergies? _____**

☐ ☐ **Does your child have any persistent or intermittently occurring skin rashes? _____**

☐ ☐ **Does your child take vitamin supplements? _____**

☐ ☐ **Does your child eliminate stools each day? _____**

☐ ☐ **Does your child have any digestive problems? _____**

For how many months was your child breast-fed? _____

What does your child usually eat for Breakfast? _____

What does your child usually eat for Lunch? _____

What does your child usually eat for Dinner? _____

What does your child usually eat for Snacks? _____

How much cow's milk does your child drink each day? _____

What is your child's favorite food? _____

What type of fast foods does your child like to eat? _____