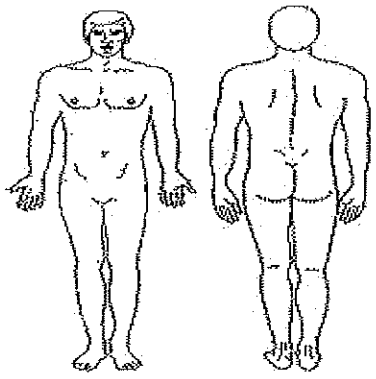
ABOUT THE PATIENT

Name_____ Birth Date _____
Name of Parents/Guardians _____
Sibling's names and ages _____
Address_____City_____State____Zip_____
Phone: Home _____ Cell _____ Work _____
E-mail address _____
Would you like us to email you our free newsletter? ☐Yes ☐No

REASON FOR THIS VISIT

Describe the purpose of this visit _____
_____
When and how did this health challenge begin?_____
_____
Since the problem began, is it:
☐Getting Better ☐Getting Worse ☐About the Same
Using the diagram to the right please indicate with an X where you or your child notices discomfort or problems occurring. →
What is the pattern of this problem?
☐ Constant ☐Intermittent ☐Occasional ☐Cyclic
What have you tried to improve this condition?
_____
Have you seen other professionals for this condition? ☐ Yes ☐ No
Dr.'s Name (s) _____
Type of Treatment _____
What are your objectives in consulting us? _____



HEALTH HISTORY

Who referred you to this office?_____
Have you been adjusted by a Chiropractor before? ☐ Yes ☐ No
Previous Chiropractor's Name _____
Date of Last Visit _____Reason for those visits?_____
Name of Pediatrician: _____ Frequency of Visits:_____
Date of last visit: _____Reason:_____
Number of doses of Antibiotics your child has taken:
During past six months_____ Total during lifetime_____
Number of doses of other prescription medications your child has taken:
During past six months_____ Total during lifetime:_____
Please list_____
Please list any OTC drugs taken in past six months_____
Has your child ever been hospitalized, had any surgeries or major illnesses?
☐ No ☐ Yes, please explain _____
Vaccination History _____ Any reactions?_____
Have you withheld any Vaccines? ☐ No ☐ Yes Why?_____