

Discover Life Chiropractic
 2956 Ginnala Dr. Ste 102
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WELCOME

ABOUT YOUR CHILD

Today's Date: ____ / ____ / ____

Child's Name: _____

Child's Nickname: _____ Boy Girl

Reason For Visit: _____

Birthdate: ____ / ____ / ____ Age: ____ Grade: ____

School: _____ SS#: _____

Child's Home Phone#: _____

Child's Home Address: _____

STREET ADDRESS

CITY STATE ZIP

Referred By: _____

WHO IS ACCOMPANYING THIS CHILD TODAY

Name: _____

Relation: _____

Are You The Legal Guardian of This Child? _____

YOUR CHILD'S MEDICAL HISTORY

What Is Your Child's Blood Type? _____

List Any Allergies Your Child Has. _____

List Any Prescription / Over The Counter Medications _____

Your Child Is Taking. _____

List Previous Surgeries / Treatments with Dates. _____

Does Child Have or Ever Had Any Of The Following Illnesses.

Measles ____ / ____ German Measles ____ / ____

Scarlet Fever ____ / ____ Mumps' ____ / ____ Chicken Pox ____ / ____

Cancer ____ / ____ Pneumonia ____ / ____

Urinary Tract Infection ____ / ____ HIV/AIDS ____ / ____

Rheumatic Fever ____ / ____ Diabetes ____ / ____ Tuberculosis ____ / ____

Other illnesses/accidents? _____

DEVELOPMENT / NUTRITION

Birth Weight _____ Length at Birth _____

Sat Alone ____ / ____ Stood Alone ____ / ____

Walked Alone ____ / ____ First Words ____ / ____

First Tooth ____ / ____ Toilet Trained ____ / ____

Breast Feeding Formula Vitamins/FE/Flouride

FAMILY INFORMATION

Parent's Marital Status:

Single Married Divorced Widowed Separated

Mother's Name: _____

Biological Step Mother Guardian

Mother's Current Physical Health Is: Good Fair Poor

Mother's Blood Type Is ____ and RH is _____

Birthdate: ____ / ____ / ____ Home Phone #: _____

Employer: _____ Work Phone #: _____

SS#: _____ D.L.#: _____

Father's Name: _____

Biological Step Father Guardian

Father's Current Physical Health Is: Good Fair Poor

Father's Blood Type Is ____ and RH is _____

Birthdate: ____ / ____ / ____ Home Phone #: _____

Employer: _____ Work Phone #: _____

SS#: _____ D.L.#: _____

Who Is Responsible For Making Appointments?

Mother Father Other (Below)

Name: _____

Work Phone #: _____

Home Phone #: _____

Please List Any Other Children (Please include birthdates and gender)

Please continue on back

In the Event Of An Emergency, Who Should We Contact?

Their Name: _____ Relation: _____

Work Phone #: _____ Home Phone #: _____

ACCOUNT INFORMATION

Person Ultimately Responsible For Account

Name: _____ Relation: _____

Billing Address: _____

Home Phone #: _____ Employer: _____ Work Phone #: _____

SS#: _____ Driver's License #: _____

Desired Method of Payment:

Cash Check Credit Card and Card # _____ Exp. Date: ____/____/____

Name As It Appears On Card: _____

We invite you to discuss frankly with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider, parent and patient.

Our office policy requires payment in full for all services rendered at the time of visit. The person bringing the patient to this office is responsible for the charges unless other arrangements have been made with the business manager. If the account is not paid _____ and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.

I hereby authorize payment of benefits directly to provider of benefits due me for services rendered. I further authorize the physician and/or supplier to release any information required to process insurance claims.

I understand the above information, guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my child's medical status.

Date: ____/____/____ Signature of Responsible Person: _____

PEDIATRIC CONSULTATION

Name _____ Date _____

The vast majority of our patients have experienced literally dozens of impacts that could cause subluxated vertebra. What I want to do now is discover several of yours.

What was your child's birth like? _____

How long entire labor? _____ How long did you actually push? _____

Were you induced? Yes No Nerve block? Yes No C-section? Yes No

Was there any pulling on the head? Yes No Forceps or vacuum extraction used? Yes No

47% of all children fall on their head by the age of one and they have at least 200 more major falls by the age of 5 years old.

When was (name)'s most recent fall? _____

Was any care given? _____ Was s/he checked by a chiropractor? _____

And the fall before that? _____ Any care given? _____

What sports or recreational activities does s/he do? _____

When was (name)'s most recent stress, strain, or injury while doing these activities? _____

Care given? _____

Has (name) been involved in a motor vehicle accident as a passenger? Yes No

Briefly describe: _____

Any treatment received? _____ Chiropractic? _____

These sound important. Thank you for explaining your (son/daughter)'s history of accidents and traumas. This will help the doctor better understand the case. What I want to do now is ask you a few questions regarding (name)'s current health concerns.

Does s/he have any health concerns? _____

If so, how long? _____

Subluxated vertebra can cause irritation to different fibers within nerves that can affect any organ or tissue, causing conditions now or in the future.

Are there any other conditions s/he is or was experiencing? _____

How long? _____

Depending on the type and degree of the subluxated vertebra, the nerve pressure can be constant or occasional. How often does (name) have this condition? _____

Any medications? _____