NEW PATIENT FORM CHILD

Patient Name ______________________________ *Please mark the conditions that apply to you.*

PATIENT INFORMATION

Child's Name ______________________________ Today's Date ____________ Referred by ____________

Address ______________________________ City ______________ State ______ Zip ____________

Mother's Name ______________________________ Father's Name ______________________________

Home Phone ______________ Mother's Phone ______________ Father's Phone ______________

Birthday ____________ Age ________ Gender ☐ M ☐ F Are you pregnant? ☐ No ☐ Yes

Your Employer ______________________________ Occupation ______________________________

e-Mail Address ______________________________ Have you been to a chiropractor before? ☐ No ☐ Yes

Emergency Contact ______________ Relation ______________ Phone ______________

Name of Medical Doctor ______________________________ Phone ______________________________

REASON FOR SEEKING CARE

Past	Current		Past	Current		Past	Current	
☐	☐	Headaches	☐	☐	Vision Problems	☐	☐	Asthma

What is the purpose of your visit? ☐ Preventative Wellness ☐ Complaint ☐ Auto Accident Injury ☐ Work Injury

Main Complaint ______________________________ Additional Health Concerns ______________________________

When did this begin? ______________________________

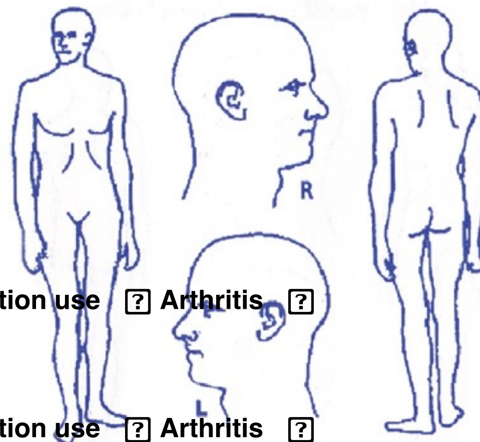
List any past auto accidents: ______________________________ Was any care received? ______________

List any past work injuries: ______________________________ Was any care received? ______________

List any past sport, recreational or home injuries:

Describe: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/Tingly

Pain radiates to ______________________________



Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other____________

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other

EALTH HISTORY

AST HISTORY

AMILY HISTORY