NEW PEDIATRIC PATIENT APPLICATION

Today's Date:_____

Full Legal Name:_____ Age:_____ Gender: M / F

Address: _____ City, State, Zip: _____

Home Phone: ( ) _____ Birth Date: _____/_____/_____ Social Security #: _____-_____-_____

Mother/Guardian Name: _____ Occupation:_____

Father/Guardian Name: _____ Occupation: _____

Siblings and ages (if applicable): _____

How were you referred to this office? _____

PURPOSE OF THIS VISIT

Chief Complaint: _____

When did this condition begin? ____/____/____

Is this condition getting worse? O Yes O No Is this condition: O Constant O Comes & goes O Activity related

Does complaint(s) interfere with: _____ School _____ Sleep _____ Sports _____ Daily Routine

BIRTH HISTORY

Birth Intervention: _____Forceps _____ Vacuum Extraction _____ Breech _____ Caesarian Section, ER or Planned?

Complications During Delivery? _____No _____Yes, List: _____

Genetic Disorders or Disabilities: _____No _____Yes, List: _____

CHILDHOOD DISEASES

Chicken Pox	N / Y, Age _____	Mumps	N / Y, Age _____
Rubella	N / Y, Age _____	Whooping Cough	N / Y, Age _____
Measles	N / Y, Age _____	Other: _____	N / Y, Age _____

Immunizations (List those received and age): _____

_____

Please check any of the following that you have experienced in the last 12 months

CERVICAL SPINE (NECK):

O Neck Pain
O Pain into your shoulders/arms/hands
O Numbness/tingling in arms/hands
O Hearing disturbances
O Weakness in grip
O Headaches/Migraines
O Dizziness
O Visual disturbances
O ADHD/ADD
O Ear Infections
O Sinusitis
O Allergies/hay fever
O Recurrent colds/flu
O Seizures
O TMJ/Pain/Clicking

THORACIC SPINE (UPPER & MID BACK):

O Indigestion/Heartburn
O Heart Palpitations/ Murmurs
O Pain on Deep Inspiration/Expiration
O Shortness of Breath
O Heart Attacks/Angina
O Recurrent Lung Infections/Bronchitis
O Pain Into Your Ribs/Chest
O Hypoglycemia
O Reflux
O Asthma/Wheezing
O Ulcers/Gastritis
O Upper Back Pain
O Mid Back Pain
O Nausea
O Tired/Irritable after eating or when you haven't eaten

OFFICE USE ONLY

LUMBAR SPINE (LOW BACK):

O Low Back Pain
O Pain into your hips/legs/feet
O Numbness/tingling in your legs/feet
O Coldness in your legs/feet
O Muscle cramps in your legs/feet
O Constipation/Diarrhea
O Scoliosis
O Bed wetting
O Colic
O Recurrent bladder infections
O Menstrual irregularities/cramping
O Weakness/injuries in your hips/knees/ankles

Other health conditions not mentioned: _____

_____

Please list any medications / past surgeries: _____

_____

DEVELOPMENTAL HISTORY

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child? _____No _____ Yes

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? _____ No _____ Yes, List: _____

Has Your Child Ever Been Involved in a Car Accident? _____ No _____ Yes, List: _____

Has Your Child Been Seen on an ER Basis? _____ No _____ Yes, List: _____

Other Traumas Not Described Above? _____ No _____ Yes, List: _____

Menstruation: _____ No _____ Yes, Age: _____

IN CASE OF EMERGENCY

Name: _____

Relationship to Patient: _____

Home Phone: ( )_____

Work Phone: ( )_____

Cell Phone: ( )_____

Do you have health insurance that can be verified for participation? O Yes / O No

If yes, please bring your card to the front desk to be copied upon completion of paperwork.

The above information is true and accurate to the best of my knowledge. If applicable, I authorize the staff of Christian Chiropractic to verify my insurance benefits for chiropractic. I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me (PATIENT). If this office chooses to bill any services to my insurance carrier, they are performing these services strictly as a service to me. Necessary reports and required information which aid in reimbursement will be provided; however my insurance company may deny my claims, and ultimately I am responsible for any unpaid balances.

Patient/Guardian Signature: _____ **Date:** _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We **DO NOT** offer to diagnose or treat any disease or condition other than **vertebral subluxation**. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do no offer to treat it, nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate intelligence. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.
(print name)

All questions regarding the doctor's **objectives** pertaining to my care in this office have been answered to my complete satisfaction. I accept chiropractic as it is explained on this basis.

_____ _____
(signature) **(date)**

Consent to evaluate and adjust a minor child:

I, _____, being the parent or legal guardian of _____
have read and fully understand the above terms of acceptance and hereby grant permission for my child to be evaluated and receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the doctor and his associates have my permission to perform an x-ray evaluation. I have been advised the x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

_____ _____
(signature) **(date)**