Child Patient Application

(12 years old and younger)

Please fill out the following information in its entirety to allow us the opportunity to better evaluate your case. If you have any questions, please feel free to ask one of our assistants. Thanks!

Patient Information:

Name: ______________________________________ **Preferred Name:** __________________ **Date:** ____/____/_____

□ **Male** □ **Female** **Birth Date:** ____/____/______ **SS#**: ______-______-_______

Address: ______________________________________ **City:** _____________________ **State:** _____ **Zip:** __________

Home Phone: ___________________________ **Email Address:** ____________________________________

Religion (Optional): ___________________________

Mother: ____ **State:** _____ **Phone:** ____________________

Occupation: ____ **Employer:** ____________________________________

Father: ____ **State:** _____ **Phone:** ____________________

Occupation: ____ **Employer:** ____________________________________

School: ____ **Grade:** _____

Referred to Office by: □ Friend/ Family ____________________________, □ Yellow Pages, □ Mail, □ Location, □TV, □ Screening, □ Paper/ Article / Report, □ Radio, □ Internet, □ Other:______________

Payment for Services by (circle): Cash, Check, Credit Card, Health Insurance, Auto Insurance, Worker's Comp.

Type of Care Desired: □ Temporary Relief □ Lasting Correction

Insurance Information:

Ins. Company Name: ____ **Phone:** ________________________

Address: _______________________________________ **City:** ____________________**State:** _____ **Zip:** __________

Group # (Plan, Local, or Policy#): ____________________________ **I.D. #:** __________________________________

Subscribers Name: ____________________________ **Subscribers SS#:** _____-____-_____ **Relation:** _____________

Date of Birth: ____/____/______ **Employer:** ___________________________________ **Years Worked:** __________

Health History:

Have You ever had any metal implants? □ Yes □ No

Have You ever been gun shot? □ Yes □ No

Please check if you have had any of these conditions:

□ Chicken pox □ Measles □ Mumps □ Rubella □ Whooping Cough □ Ear Infections

If any of the above conditions are checked, please indicate when: ____

Was the pregnancy normal? □ Yes □ No **If no, explain:** ____

Delivery: □ Home □ Hospital

Immunizations: □ Yes □ No (List those received and age when administered):

____

Health History Continued:

Have you been treated by a physician for any health condition in the last 12 months? □ Yes □ No
If Yes, please describe condition: ____________________

Surgical History:

Type of Surgery: ____________________ **Date:** ____________

Type of Surgery: ____________________ **Date:** ____________

Accident History:

□ **Job** □ **Auto** □ **Other:** ____________________ **Date:** ____________

□ **Job** □ **Auto** □ **Other:** ____________________ **Date:** ____________

Major Complaints or Symptoms: **What are you hoping we can help you with? Please rate them on a scale of 1 – 10 with *10 as the worst*.**

□ blurred vision ____	□ dizziness ____	□ loss of balance ____	□ ringing in ears____
□ buzzing ears ____	□ face flushed ____	□ loss of smell ____	□ shortness of breath
□ cold feet ____	□ fainting ____	□ loss of taste ____	□ stiff neck ____
□ cold sweats ____	□ fatigue ____	□ low resistance to colds	□ stomach upset____
□ concentration loss ____	□ fever ____	□ muscle jerking ____	□ None Present
□ confusion ____	□ head seems to heavy	□ numbness in fingers ____	
□ constipation ____	□ head aches ____	□ numbness in toes ____	
□ depression/weeping spells	□ insomnia ____	□ pins/needles in arms ____	
□ diarrhea ____	□ light bothers eyes	□ pins/needles in legs ____	

Please Write Down Any Additional Symptoms You May Be Experiencing:

____________________ **Rating:** ____ ____________________ **Rating:** ____

____________________ **Rating:** ____ ____________________ **Rating:** ____

More Vital Information: Please describe your "worst" symptom(s)

When and how did the complaints or symptoms begin/occur?____________________

____

Symptoms developed from (please circle): job related, auto accident, illness, gradual onset or unknown cause

Symptoms have persisted for: ____ hour(s) ____ day(s) ____ week(s) ____ month(s) ____ year(s)

Sypmtoms □ Come and Go □ Are Constant □ Are Nearly Constant

Have you been treated by a medical physician for this condition before? □ Yes □ No

-If yes, where and by whom? ____________________

Are you taking any medications? □ Yes □ No If yes, what? ____________________

Are you allergic to any medications? □ Yes □ No If yes, what? ____________________

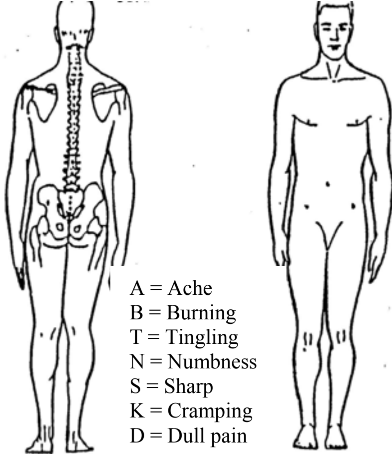
Please circle the motions that aggravate symptoms: bending, coughing, lifting, lying down, reaching, sitting, sneezing, standing, straining at stool, turning head, other: ____________________

Please circle the motions that relieve symptoms: bending, coughing, lifting, lying down, reaching, sitting, sneezing, standing, straining at stool, turning head, other: ___

Does your pain radiate? □ Yes □ No

-If yes, where does it radiate to? ___

Please Circle the Areas of the Body Where You Are Experiencing Pain



Below, please circle the severity and intensity of your symptoms, at its worst:

Slight Mild Moderate Severe

1 2 3 4 5 6 7 8 9 10

On the scale below, please circle the percentage of time that you experience your main complaints:

Occasional Intermittent Frequent Constant

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Review of Systems: If yes, please describe the condition on the line provided.

Recent weight loss or weight gain (how much): □ Yes □ No ___

Rashes, hives or lesions: □ Yes □ No ___

Hay fever, sinuses or nasal discharge: □ Yes □ No ___

Chest pain or palpitations: □ Yes □ No ___

Shortness of breath, wheezing or coughing: □ Yes □ No ___

Nausea, vomiting or diarrhea: □ Yes □ No ___

Frequency with urination or urgency to urinate: □ Yes □ No ___

Lymphadenopathy (swelling of lymph nodes): □ Yes □ No ___

Polyuria or polydipsia (excessive thirst or urination): □ Yes □ No ___

History of seizures or headaches (how often): □ Yes □ No ___

Consent to Treatment of a Minor

I hereby authorize New Life Chiropractic Center, P.C. and whomever he or she may designate as assistants to administer Chiropractic Care as deemed necessary to my ___ (indicate your relationship to the minor) ___.

Name of Minor

Print Name: ___ (Parent or Guardian)

Sign: ___ (Parent or Guardian)

Family Health History

The reason for this form is to assist the doctor by providing past health history information for their review.

Condition Deceased Local	**Self** ☐ ☐	**Father** ☐ ☐	**Mother** ☐ ☐	**Spouse** ☐ ☐	**Brothers** ☐ ☐	**Sisters** ☐ ☐	**Children** ☐ ☐
Allergies							
Arthritis							
Asthma							
Back Trouble							
Cancer							
Constipation							
Diabetes							
Disc Problems							
Drug Addiction							
Ear Infections							
Emphysema							
Fibromyalgia							
Headaches							
Heart Trouble							
High Blood Pressure							
Hyperactivity/ ADHD							
Kidney Trouble							
Menstrual Cramps							
Migraine							
Neck Pain							
Nervousness							
Numbness							
Pinched Nerve							
Poor Circulation							
Scoliosis							
Shoulder/Arm/Hand							
Sinus Trouble							
Stomach Trouble							
Other: ______________							