

Kids Chiropractic Intake

(11 & Under)



PATIENT INFO

First Name _____ MI _____ Last _____ Birth Date ____ / ____ / ____
 Address _____ City _____ State ____ Zip ____
 Home # _____ Cell # _____ Email _____
 Can we send you occasional text messages for important reminders? Yes No
 Gender _____ # of Siblings _____ Parents Names _____
 Who may we thank for referring you to our office? _____

HOW CAN WE HELP YOUR CHILD?

What brings you in today? Wellness Checkup Other: _____

 If your child is already experiencing a symptom, what is it? _____

 How long has this condition persisted? _____
 If he/she is experiencing pain, is it: Sharp Dull Comes and Goes Travels Constant
 Since the problem started, is it: About the same Getting Better Getting Worse
 Have you seen other doctors for this condition? _____
 Name of previous chiropractor? _____
 Any additional comments? _____

PREGNANCY

Did you experience any of the following during your pregnancy? (Check all appropriate boxes)

Back / Other Pain Gestational Diabetes Hyperemesis Gravidarum Swelling Strep B
 Pre-Term Fatigue Nausea / Vomiting Pre / Eclampsia Other

If other, please explain: _____

Was baby ever in breech position? Yes No How many ultrasounds were performed? _____

BIRTH HISTORY

Type of birth (check all that apply):

Home Birthing Center Hospital Vaginal Breech
 C-Section Scheduled / Induced Epidural Forceps Vacuum

Problems during labor / delivery? _____

Antibiotics Congenital Anomalies Failure to Thrive Jaundice Meconium
 Respiratory Distress Extended Hospitalization Other: _____

FOR OFFICE USE ONLY:

INSURANCE: _____ PATIENT NUMBER: _____

Infant Feeding: Breast Bottle Formula

Number of hours of sleep each night: _____ Quality of Sleep: _____

At what age did the child: _____

Hold head up: _____ Sit unsupported: _____ Crawl: _____ Stand: _____ Walk unsupported: _____

Have you vaccinated your child? No Yes As Scheduled Delayed

Has your child had (check all that apply):

CHICKEN POX MEASLES RUBEOLA

MUMPS RUBELLA PERTUSSIS / WHOOPING COUGH

Has your child ever suffered from (check all that apply)?:

ALLERGIES BROKEN BONES DELAYED SPEECH HYPERACTIVITY SINUS TROUBLE

ASTHMA CHRONIC EAR ACHES DIABETES JOINT PROBLEMS WALKING PROBLEMS

BED WETTING COLDS / FLU DIGESTIVE ISSUES POOR APPETITE

BEHAVIORAL PROBLEMS COLIC HEADACHES

Allergies (Please List)	Medications (Please List)	Supplements (Please List)
_____	_____	_____
_____	_____	_____

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

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 each patient understands both the objective and the method that will be able 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 specific adjustments of the spine. Our philosophy involves “open-bay” adjusting. Should you have personal questions, we do have adequate space for that.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or 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 a chiropractic spinal evaluation, 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 not 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 wisdom. Our only method is specific adjusting to correct vertebral subluxations.

Dynamic Family Chiropractic Policies / Procedures:
(Please Initial Next to Each Line)

- _____ 1. All initial services and subsequent fees are payable when services are rendered. (Co-pays, deductibles, etc.) Failure to pay will result with balances being transferred to a collection agency.
- _____ 2. I have read and understand The Notice of Privacy Act (HIPPA forms, behind New Patient Paperwork) and a copy will be provided to me if requested.
- _____ 3. I authorize Dynamic Family Chiropractic to use my child(s) photographs for education or marketing purposes.

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

_____ Signature

_____ Date