Kids Chiropractic Intake

(11 & Under)

Dynamic Family Chiropractic
Wellness Center

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:**_____

GROWTH & DEVELOPMENT

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

BASICS

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

DYNAMIC FAMILY CHIROPRACTIC TERMS OF ACCEPTANCE

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