NEW PATIENT APPLICATION FOR CHILD

Welcome to our practice! Please <u>thoroughly</u> complete all questions. Thank you!

Child's Name_____ Today's Date_____/_____/_____

Birthdate_____/_____/_____ Age_____ Height _____ Weight _____ M __ F __

Address_____ City/State/Zip_____

Mother's Name _____
Employer_____
Marital Status: S/M/D/W (circle one)
Home Phone (_____)_____
Work Phone (_____)_____
Cell Phone (_____)_____
E-Mail _____

Father's Name _____
Employer_____
Marital Status: S/M/D/W (circle one)
Home Phone (_____)_____
Work Phone (_____) _____
Cell Phone (_____) _____
E-Mail _____

Name & Age of Sibling(s) _____

Who may we thank for referring you?_____

Health Reasons For Consulting Our Office:

1._____ 3._____

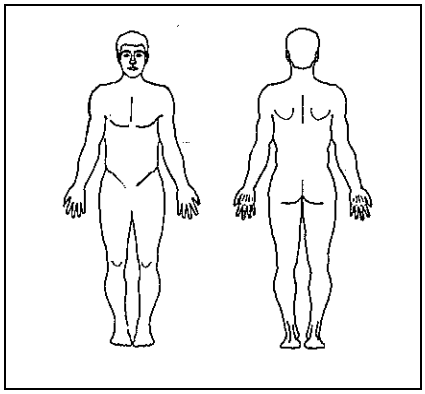
2._____ 4._____

Has your child had similar problem(s) before? _____Yes _____No

Current Complaint (how your child feels today): Please Circle

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

Mark Area of Health Concerns



Front Back

How often are your child's symptoms present?

(Occasional) ___ 0-25% ___26-50% ___51-75% ___76-100% (Constant)

How long have your child's symptoms been present?_____

In the past week, how much has your child's problem interfered with their daily activities?
(for example work, social activities, household chores) Please Circle

0 1 2 3 4 5 6 7 8 9 10
No Interference Unable to carry on any activities

Previous Chiropractor_____Last Visit_____
Reason for care_____

General Practitioner_____ and city_____

Has your child had any (circle all that apply) X-rays, MRI, CT Scan for your area(s) of complaint?
___Yes ___No Date Taken_____ What areas were taken?_____
Is this the result of an auto injury? ___Yes ___No If so, when? _____

Other Doctors who have treated this problem_____

Father/Mother/Brother/Sister/Children, with similar problems?_____

Please check all of the following that apply to your child.

___Alcohol/Drug Dependence
___Recent Fever
___Diabetes
___High Blood Pressure
___Stroke (Date)_____
___Corticosteroid Use (Cortisone, Prednisone, etc.)
___Taking Birth Control Pills
___Dizziness/Fainting
___Numbness in Groin/Buttocks
___Epilepsy/Seizures
___Menstrual Problems
___Urinary Problems
___Currently Pregnant, # Weeks ___
___Abnormal Weight ___Gain ___Loss
___Marked Morning Pain/Stiffness
___Pain Unrelieved by Position or Rest
___Pain at Night
___Visual Disturbances

___Tobacco Use – Type_____Frequency_____/Day

___Cancer/Tumor (Explain)_____

___Surgeries_____

___Medications_____

___Other Health Problems (Explain)_____

___None of the Above

Parents:
What have you heard about chiropractic?_____

Do you know what a subluxation is? ___Yes ___No

If yes, please describe_____

What daily rituals for spinal health do you presently practice?_____

Do you have health insurance? ___Yes ___No Insurance Plan_____
Method of Payment for First Visit: ___Cash ___Check ___Credit Card

I would like my child to experience the following benefits from Chiropractic Care:
___ Symptomatic relief of pain or discomfort
___ Correction of the cause of the problem as well as relief of symptoms
___ Prevention of future problems
___ Healthier spine and nerve system
___ Optimal health on all levels
___ Other - Please explain _____

The above information is true and accurate to the best of my knowledge. My reasons for consultation with the Doctor is for the evaluation of my physical health and the potential for improvement.

Parent or Guardian Signature: _____ Date: _____ / _____ / _____

Brown Chiropractic
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