

PARENT/ CHILD HEALTH INTAKE FORM



Remember: Injury to the spine during the birth process, as well as the numerous falls and accidents during childhood, could be the unsuspected cause of many health problems in children.

Name of Parent _____	Name of Child _____
Address _____	Address (if different from parent) _____
City/ State/ Zip _____	_____
E-mail _____	_____
Phone # Work _____ (Hours ___to___)	Phone# _____ Sex M F
Home _____	Date of Birth _____ Age _____
Who is responsible for your child's bill? You Spouse Auto Insurance	Personal Health Insurance

During pregnancy, were you on medication? Did you smoke or consume any alcoholic beverages?

Was there back pain? _____

Approximately how long was labor? _____

Were you physically ill? (colds, flu, allergies, German measles, anything like that) _____

If so, what? _____

Regarding Labor:

Was it chemically induced? Yes No

Doctor assisted? Yes No

Was C-section performed? Yes No

Were forceps used? Yes No

Did doctor have hands on the infant? Yes No

Were you lying down? Yes No

Was family member present? Yes No

If yes, who? _____

(95% of all infants were born with hands on or forceps)

Was the baby premature? Yes No

If so, what was his/her age and weight? _____

Did your child suffer from health problems, such as:

Headaches	Yes	No	Meningitis	Yes	No
Allergies	Yes	No	Diarrhea	Yes	No
Ear Problems	Yes	No	Constipation	Yes	No
Sleeping Disorder	Yes	No	Colic	Yes	No
Breathing problems	Yes	No	Rashes	Yes	No
Fatigue	Yes	No	Milk or Lactose Intolerance	Yes	No
Irritability	Yes	No	Bed Wetting	Yes	No
Hyperactivity	Yes	No	Digestive Problems	Yes	No
Frequent Colds	Yes	No	Other: _____		
Flu	Yes	No	_____		

Regarding your child today:

Is your child accident prone:	Yes	No	Has your child had a scoliosis examination by an approved scoliosis determination procedures clinic?	Yes	No
Has the child had any falls down steps?	Yes	No	Is your child hyperactive?	Yes	No
Has the child ever fallen from heights over 2 feet?	Yes	No	Have learning disorders?	Yes	No
Has your child ever been involved in a motor accident?	Yes	No	Sleeping difficulty?	Yes	No
Has your child ever been hospitalized or had surgery?	Yes	No	Poor Posture?	Yes	No
Does you child suffer from:			Does your child have any problems associating with friends?	Yes	No
Allergies	Yes	No	Is your child nervous, or has anyone suggested that your child was nervous?	Yes	No
Asthma	Yes	No	Does your child show any signs of nervousness twitching, or excessive talking to themselves?	Yes	No
Headaches	Yes	No	Has your child ever had any broken bones Or sprain injuries?	Yes	No
Has your child ever had any broken bones Or sprain injuries?	Yes	No	If you could improve one aspect of your child's health or behavior, what would it be? _____		
Is you child on any medication?	Yes	No	_____		

PARENT'S GENERAL HEALTH SURVEY

Please discuss any health conditions that may be affecting you, such as:

Arthritis _____

Back Pain _____

Allergies _____

Headaches _____

Fatigue _____

Diabetes _____

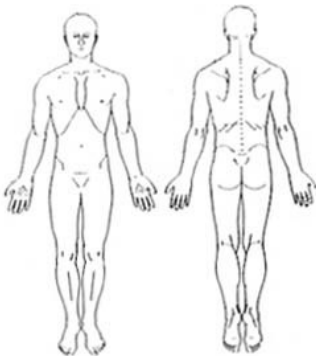
Tiredness _____

High Blood Pressure _____

Asthma _____

Bursitis _____

Others _____



Please outline, on the diagram above, the area of your child's pain or discomfort.

DO NOT WRITE IN THIS AREA

I understand and agree that health and accident Insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my child's condition as he deems appropriate through use of manipulation throughout his/her spine. It is understood and agreed the amount paid the Doctor, for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Parent or Guardian's
Signature Authorizing Care _____ 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 specific adjustments of the spine.

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 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 another health care provider.

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.

I, _____ have read and fully understand the above statement.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(Signature)

(Date)

Consent to evaluate and adjust a minor child.

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