VERTICAL
CHIROPRACTIC

AGES 10-17 CHILD CONFIDENTIAL HEALTH INFORMATION

PATIENT INFORMATION *all fields required*

Print Full Name: _____ Name you go by: _____ Date: _____
Parent / Guardian's Names: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Age: _____ Birth Date: _____ Sex: ☐ Male ☐ Female Number of siblings _____
Most of our patients are referred to our office by a caring family member or friend. How did you hear about our office or who referred you? _____

PHONE NUMBERS

Home: _____ Parent's Work: _____ ext. _____ Cell: _____
Preferred phone number: Home ☐ Work ☐ Cell ☐ Best time to reach you: _____
In case of emergency, notify: _____ Relationship: _____ Phone: _____
Parent / Guardian Email Address: _____

HEALTH HISTORY

Chiropractic care is for optimal health and pediatric development.
Is the purpose of this visit: ☐ Wellness Check-up ☐ Injury / Accident ☐Other
Please Explain: _____
If your child is experiencing Pain / Discomfort, please identify where and for how long: _____

- Spinal misalignments can put pressure on nerves for long periods of time. How long have you had the above problems? (If accident or injury, write date) _____
- Have you ever had this problem before? ☐Yes ☐No Have you seen other doctors for this problem? ☐ Yes ☐ No
- Nerve pressure & Irritation can be constant or occasional. How often do you have the above problems?
  ☐ It is constant OR ☐ On and off during the day OR ☐ It comes and goes throughout the week
- How is the problem now? ☐ Rapidly improving ☐ Improving slowly ☐ About the same ☐ Gradually worsening
- Irritation to different nerve fibers can create different sensations. Is yours: ☐ sharp ☐ dull ☐ throbbing ☐ burning ☐ numb ☐ achy ☐ tingling ☐ radiating?
- Rate your current pain intensity from 0 to 10 with 10 being the worst pain: 0 1 2 3 4 5 6 7 8 9 10
- Spinal misalignments can cause weakening of the entire spine. Is yours worse in the morning, evening, or after a specific activity? _____
- What makes your condition better? _____
- Poor posture leads to poor health, and often indicates spinal problems.
  How would you rate your posture: ☐ Poor ☐ Good ☐ Excellent

MEDICATIONS & SURGERY

Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications or OTC drugs are you currently taking? _____
_____
Many people with spinal problems experience health crisis before seeking chiropractic care. Have you had any major hospitalizations or surgeries that the doctor should know about? Yes ☐ No ☐ If YES, please explain:
_____

PRENATAL HISTORY

List any complications during pregnancy: _____
Complications during delivery: _____
Medications during pregnancy / delivery: _____
Birth Intervention: ☐ Forceps ☐Vacuum Extraction ☐Caesarian Section

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The vast majority of our patients have experienced dozens of falls or impacts (auto/school/sports/hobby related) that could cause spinal misalignments. Help us discover a few of yours.

- Which of the following sports have you been involved in? ☐Football ☐Ski / Snowboard ☐Soccer ☐Running ☐Gymnastics/Cheerleading ☐Martial Arts ☐Horseback riding ☐Other; _____
- Have you ever… ☐ Fallen down the stairs ☐Slipped/Fell on the ground (or ice) ☐Had a sports injury ☐ Broken a bone if so, which one? _____
- Have you been involved in any automobile accidents or minor fender benders? ☐ Yes ☐No Date: _____
- Any traumas not listed above: _____

Name of Family Doctor / Pediatrician? _____
Have you ever been seen on an emergency basis? ☐ Yes ☐ No Reason / Date: _____
Exercise: ☐ None ☐1-3x week ☐4-7x week ☐Gym ☐Sports ☐Other: _____

PAST HISTORY

Have you ever been diagnosed with any of the following conditions? Please check ☑ all that apply:
☐Broken bone ☐Dislocations ☐Tumors ☐Rheumatoid Arthritis ☐Fracture ☐Disability ☐Cancer ☐Allergies
☐Heart Attack ☐Osteoarthritis ☐Diabetes ☐Cerebral Vascular ☐Asthma ☐Fatigue ☐Digestive Problems
☐Sciatica ☐Genetic Disease ☐Other _____

CHIROPRACTIC HISTORY

Research shows that your spine should be checked regularly. When did you last see a chiropractor? _____
Reason for care: _____ Favorable outcomes? Yes / No Did you follow recommendations? Yes / No
Who else in your family is under chiropractic care? _____

ACKNOWLEGMENTS

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

_____ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

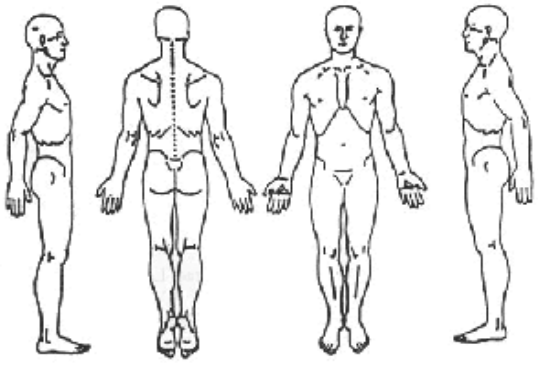
_____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, text messages, or health information to me as an extension of my care in this office.

_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Please place an "X" on the diagram to the right where you have any pain, numbness, tingling, or other problems.



_____
Patent / Guardian Signature Date

_____
Doctor Signature Date