

STONE FAMILY CHIROPRACTIC CENTER - Ages 10-17

Thank you for choosing our office to take care of your health needs.
To help us serve you better, please complete the following information.

Today's Date: _____

PATIENT INFORMATION

Print Full Name: _____ Name you go by: _____

Parent's/Guardian's Names: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Height: _____ Weight: _____ Date of Birth: _____ Social Security #: _____

Please Check: Sex: Male Female Number of siblings _____

Where did you hear about our office or who referred you? _____

Phone Numbers:

Home: _____ Parents Work: _____ ext. _____ Cell/Other: _____

Parent/Guardian E-mail address: _____

INSURANCE

Do you have medical insurance? Yes No Insurance Company Name: _____

Policy Number: _____ Insurance Company Phone Number: _____

Insured's Name (if different from patient): _____ Relationship to patient: _____

Insured's Date of Birth: _____ Insured's Social Security Number: _____

Insured's Employer: _____ Insured's employer address: _____

HEALTH HISTORY

Reason for seeking chiropractic care: _____

Is this due to an accident or injury? Yes No Date: _____ Type of accident: Auto Other: _____

Does it interfere with your (circle all that apply): Work/School Sleep Daily routine Exercise

Have you seen other doctors for this condition? Yes No Dr's name: _____

Please fill in the blanks below describing the chief complaint that you have:

- Vertebral subluxations can put pressure on nerves for long periods of time. **How long** have you had the above complaints? _____
- Nerve pressure & irritation can be constant or occasional. **How often** do you have the above complaints? _____
- Irritation to different nerve fibers can create different sensations. Is your **sharp, dull throbbing, burning, numb** and/or **achy**? _____
- Subluxations can cause weakening of the entire spine. Is your worse in the **morning, evening, and/or after a specific activity**? _____

CHIROPRACTIC HISTORY

Have you ever been to a chiropractor before? Yes No Date of last chiropractic visit: _____

Are other family members under chiropractic care? Yes No Who? _____

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

- Which of the following sports have you been involved in? Football Basketball Soccer Running Gymnastics/Cheerleading Martial Arts 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 car accidents/fender benders? Yes No Date _____

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: _____

Please list any past surgeries and dates: _____

Any traumas not listed above: _____

Have you ever experienced (check all that apply):

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Walking/Foot Pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> "Growing Pains" |
| <input type="checkbox"/> Fainting/Seizures | <input type="checkbox"/> Leg/Foot Pain | <input type="checkbox"/> Allergies | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> ADD / ADHD |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Female Problems | |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Male Problems | |

MEDICATIONS

Please list number of doses of antibiotics you have taken

During the past 6 months: _____

During your lifetime: _____

Please list name and number of doses of any medications (prescription or OTC) taken:

During the past 6 months: _____

During your lifetime: _____

Vaccination history: _____

PRENATAL HISTORY

Please list any complications during pregnancy: _____

Number of ultrasounds during pregnancy: _____

Complications during delivery: _____

Medications during pregnancy/delivery : _____

Birth intervention: _____ Forceps _____ Vacuum _____ Caesarian: planned or emergency: _____

I hereby authorize Stone Family Chiropractic Center and its Doctors to administer such to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office. I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself, and that I am personally responsible for payment of any and all services non-covered. I also understand that if I suspend or terminate my child's care and treatment, any fees for professional services rendered will immediately be due and payable.

Parent/ Guardian Signature

Date