

Freedom Family Chiropractic

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Patient Demographics

1. ABOUT THE PATIENT

First Name -		Last Name -	
Birthday -	Age -	Gender ☐ Male ☐ Female ☐ Other	
Birth Height -		Current Height -	
Birth Weight -		Current Weight -	
Street Address -			
City -	State/Province -		Zip Code -
Mother's Name -		Mother's Birthdate -	
Mother's Mobile Phone -		Mother's Email -	
Father's Name -		Father's Birthdate -	
Father's Mobile Phone -		Father's Email -	
Who do you prefer we contact? ☐ Mom ☐ Dad ☐ Either	Pediatrician Name -		Pediatrician Location -
Number of children -	Children's and Ages -	Have you ever been to a chiropractor before? ☐ Yes ☐ No	
Who can we thank for referring you? Or how did you hear about us? -			

2. PREVIOUS CHIROPRACTIC CARE

When was your last adjustment?

-

Name of Previous Chiropractor(s)

-

History of Complaint(s)

3. What is the purpose of your child's visit?

- ☐ **Wellness Check-up** ☐ **Injury/Accident**
☐ **Problem/Condition** ☐ **Other**

If Other, please explain

-

4. Primary Complaint

What is your child's primary complaint? (Main problem/condition that you'd like help with)

-

When did the problem begin?

-

Was the onset:

- ☐ **Gradual** ☐ **Sudden** ☐ **Unknown**

Have they seen any other doctors for this problem?

- ☐ **Yes** ☐ **No**

If yes, whom?

-

If yes, when?

-

What kind of results did you experience?

- ☐ **Helped a lot** ☐ **Helped a little** ☐ **Was no help** ☐ **Made it a little worse**
☐ **Made it way worse**

Would you say the problem is:

- ☐ **Getting Worse** ☐ **Staying the Same** ☐ **Getting Better**

Has this problem occurred before?

- ☐ **Yes** ☐ **No**

If yes, when?

-

If yes, what was the previous treatment?

-

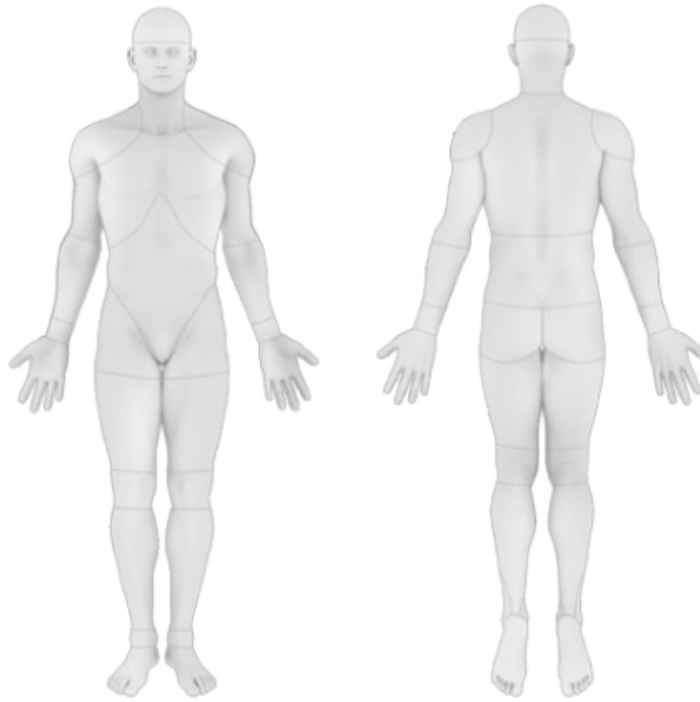
Any additional information you want to share with the doctor about this problem?

-

Does your child have any additional problems/conditions?

- ☐ **Yes** ☐ **No**

5. Please mark the areas on the body diagram where your child experiences symptoms:



6. Additional Problems

1. Problem -	How long has it been an issue? -	Constant or Occasional -
Type of Pain -	At its worst? -	At its best? -

2. Problem -	How long has it been an issue? -	Constant or Occasional -
Type of Pain -	At its worst? -	At its best? -

3. Problem -	How long has it been an issue? -	Constant or Occasional -
Type of Pain -	At its worst? -	At its best? -

Past History

7. Has your child had any surgeries in the past?

☐ Yes ☐ No

Has your child had any hospitalizations in the past?

☐ Yes ☐ No

Has your child ever been involved in any auto collisions?

☐ Yes ☐ No

8. If yes, please list past surgeries, year of surgery, type of surgery and any important notes related to the surgery:

-

9. If yes, please list past hospitalizations, year of hospitalizations, reason for hospitalizations and any important notes related to the hospitalizations:

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10. If yes, please list past auto collisions, year of collisions, treatment(s) received and any important notes related to the collisions:

-

Medications

11. Does your child currently take any medications or supplements, including any over-the-counter medications, herbs or vitamins?

☐ Yes ☐ No

12. List all medications your child is taking, including any over-the-counter medications, herbs or vitamins: (Please include name, dosage, frequency and reason for taking)

-

13. Has your child ever suffered from: Please check all that apply

- | | | | |
|--|--|---|---|
| ☐ Headaches | ☐ Behavioral Problems | ☐ Poor Appetite | ☐ ADD/ADHD |
| ☐ Stomach Aches | ☐ Sinus Trouble | ☐ Bed Wetting | ☐ Constipation |
| ☐ Poor Posture | ☐ Fall in Baby Walker | ☐ Anemia | ☐ Frequent Colds/Flu |
| ☐ Orthopedic Problems | ☐ Dizziness | ☐ Colic | ☐ Fainting |
| ☐ Heart Trouble | ☐ Scoliosis | ☐ Ruptures/Hernia | ☐ Diarrhea |
| ☐ Walking Trouble | ☐ Fall from crib | ☐ Learning Disorder | ☐ Digestive Disorders |
| ☐ Neck Problems | ☐ Sleeping Problems | ☐ Seizures/Convulsions | ☐ Chronic Earaches |
| ☐ Back Problems | ☐ Reflux | ☐ Asthma | ☐ Fall from bed or couch |
| ☐ Fall down stairs | ☐ Diabetes | ☐ Allergies | ☐ Other |

Please explain any allergies and/or other conditions/problems your child has:

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I certify that the information contained in my health history is correct to the best of my knowledge. I will not hold my doctor or any staff member of Freedom Family Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. I hereby authorize payment to be made directly to Freedom Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Freedom Family Chiropractic for any and all services I receive at this office.

Signature

Date Signed

-

Printed Name

Email

-

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