PATIENT HEALTH

ABOUT THE CHILD

Name ____

Address ____

City________________ State_______ Zip___________

Home phone _____________________________________

Birth date ____________________

SS#____

Age ________ Gender Weight___________

ABOUT THE PARENT

Name____

Employer____

Work address ______________________________________

Work phone __________________Cell_________________

Type of work ______________________________________

E-mail address_____________________________________

Social Security # ___________________________________

Insurance Co:______________________________________

Insured's Name:_____________________________________

Insured's SS#:________________________ DOB:_________

VACCINATIONS

Have you chosen to vaccinate your child? **Yes** **No**

If yes, circle all that your child has received.

DPT **MMR** **Chicken Pox** **Hepatitis** **Other**

Describe any and all reactions to vaccine(s). _____________

____

REASON FOR THIS VISIT

Describe the purpose of this visit __________________

____

Is the purpose of this appointment related to

Sports **Auto** **Fall** **Home Injury** **Other**

Please explain _________________________________

When did this condition begin? ___________________

Has this condition:

Gotten worse **Stayed constant** **Comes and goes**

Does this condition interfere with:

Sleep **Daily routine** **Other activities**

Please explain _________________________________

____

Has this condition occurred before? **Yes** **No**

Please explain _________________________________

Have you seen other doctors for this condition? **Yes** **No**

Doctor's Name(s) _______________________________

Type of treatment _______________________________

Results ______________________________________

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that	Yes	No
* Doctors of Chiropractic work with the nervous system?	☐	☐
* The nervous system controls all bodily functions and systems?	☐	☐
* Chiropractic is the largest natural healing profession in the world?	☐	☐
* If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?	☐	☐

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? ____

Have you been adjusted by a Chiropractor before? **Yes** **No** Reason for those visits? ____________________

Doctor's name________________________________ Approximate date of last visit _____________

Has any adult in your family seen a Chiropractor? **Yes** **No**

Has any child in your family seen a Chiropractor? **Yes** **No**

MOTHER'S PREGNANCY & LABOR

During Pregnancy:

☐ Drugs / Medicine ☐ Tobacco / Alcohol

Please explain ________________________________

Any illness during your pregnancy?____________________

____

How was your delivery? ____________________________

☐ Labor chemically induced ☐ Labor was Dr. assisted
☐ C-section delivery ☐ Forceps/Vacuum extraction?
☐ Did Dr. pull or twist baby? ☐ Premature delivery

Please explain ____________________________________

Did you nurse the baby? **Yes No**

Did your baby have colic? **Yes No**

Feeding problems? **Yes No**

Vaccinations? **Yes No**

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

☐ Allergies
☐ Asthma
☐ Attention problems
☐ Bed wetting
☐ Breathing problems
☐ Colic
☐ Constipation
☐ Digestive problems
☐ Ear problems
☐ Frequent colds
☐ Headaches
☐ Hyperactivity
☐ Irritability
☐ Skin problems
☐ Sleeping disorders
☐ Tubes in the ears
☐ Vision problems
☐ Other

CHILD'S CURRENT HEALTH STATUS

	No	**Yes**	**If Yes, please explain**
Has your child ever:			
…taken antibiotics?	☐	☐	____________
…been hospitalized?	☐	☐	____________
…had a severe fall?	☐	☐	____________
…been in a car accident?	☐	☐	____________
Is your child			
…accident prone?	☐	☐	____________
Had Surgery? Please Explain…			____________
…currently taking any medication (s)?	☐	☐	____________
…having difficulty interacting with others?	☐	☐	____________

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?

____

What changes (if any) in your child's health or behavior would you like accomplished? ______________

____

AUTHORIZATIONS

It is understood and agreed that the payments to the doctor for x-rays is for examination of x-rays only. The x-ray films will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient in this office.
I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable.

I authorize the use of this signature to allow the insurance companies to pay Lund Family Chiropractic directly any amounts payable as my assignment of benefits. I authorize the use of this signature on any insurance submissions.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Dr. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (If applicable) directly to the provider for services rendered.

Name of parent or guardian:______________________________Date:__________________

HISTORY AND EVALUATION

Chief Concerns:____
____
____

History of Condition:____
____

Birth and Delivery:____

Childhood Injuries / Falls / Accidents:_____________________________________

Temperament / Attitude:____

Sleep:_____________________________**Nutrition:**___________________________

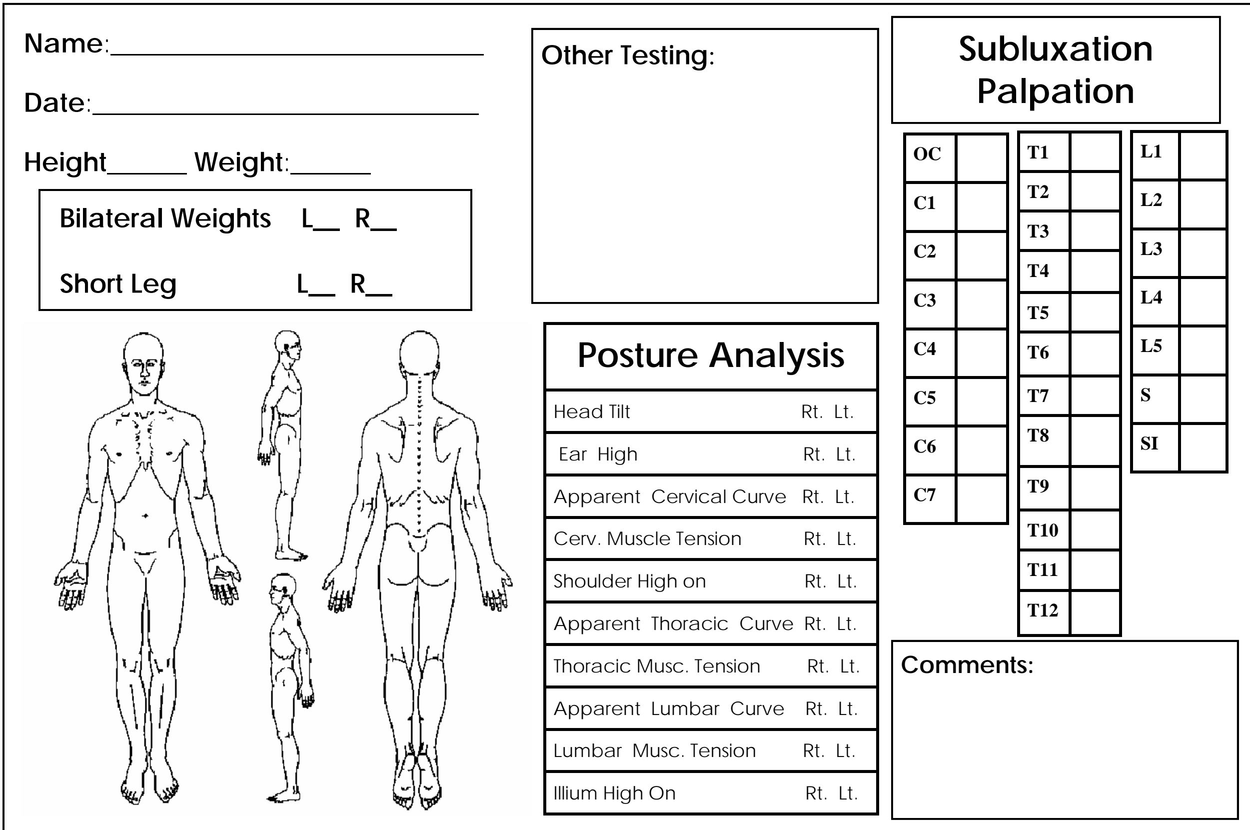
Medications:____

What has been done to help this condition (s):______________________________

Family Health History:____

Other:____

EXAM



Name:_________________________

Date:_________________________

Height______ Weight:______

Bilateral Weights L__ R__

Short Leg L__ R__

Other Testing:

Posture Analysis

Posture Analysis	
Head Tilt	Rt. Lt.
Ear High	Rt. Lt.
Apparent Cervical Curve	Rt. Lt.
Cerv. Muscle Tension	Rt. Lt.
Shoulder High on	Rt. Lt.
Apparent Thoracic Curve	Rt. Lt.
Thoracic Musc. Tension	Rt. Lt.
Apparent Lumbar Curve	Rt. Lt.
Lumbar Musc. Tension	Rt. Lt.
Illium High On	Rt. Lt.

Subluxation Palpation

OC		T1		L1	
C1		T2		L2	
C2		T3		L3	
C3		T4		L4	
C4		T5		L5	
C5		T6		S	
C6		T7		SI	
C7		T8			
		T9			
		T10			
		T11			
		T12			

Comments: