New Patient Information

Child's Name (full name please) _____ Age: _____ Date: _____/_____/_____

Address _____ City _____ State _____ Zip _____

Child's Date of Birth _____/_____/_____ Gender: *Male / Female* Weight: _____ SS# _____

Phone (Child): _____ Preferred Contact: Parent / Child / Either

Parent/Guardian Information:

Your Name: _____ Birth date: _____/_____/_____

Your Address (☐ SAME):_____

SSN#:_____ No. of Children: _____ Phone: _____

E-Mail: _____ I Am: ☐ Married ☐ Single ☐ Divorced ☐ Partnered ☐ Widowed

Occupation/Employer/School: _____

How did you hear about us? ☐ Location ☐ Doctor ☐ Internet ☐ Ins Co Referral ☐ Friend or Family Member

Who can we thank for referring you? _____

History of Concern

Reason for today's visit? _____

If your child has no symptoms or complaints, and are here for wellness services, please check (√) here ☐ and skip to **"Your Child's Health History"** Or, describe the **chief area of complaint**, including the effect it has on your child:

_____

_____

Is the purpose of this visit related to: ☐ Sports ☐ Auto ☐ Fall ☐ Home Injury ☐ Other _____

When did this condition begin? _____

Since the problem started, it is: ☐ About the same ☐ Comes & Goes ☐ Getting better ☐ Getting worse

What makes it worse: _____

Does it interfere with: ☐ Sleeping ☐ Walking ☐ Daily Routines ☐ Eating ☐ Elimination

Has your Child seen other Doctors for this problem (please list):

☐ Chiropractor _____

☐ Medical Doctor _____

☐ Other / Alternative Care _____

List any medications your child is currently taking: _____

Describe your current home stress (0 = none / 10 = extreme): _____

Rate each Area for Your Child:

Diet:	☐ Poor	☐ Good	☐ Excellent	Sleep:	☐ Poor ☐ Good ☐ Excellent
Exercise:	☐ Poor	☐ Good	☐ Excellent	General Health:	☐ Poor ☐ Good ☐ Excellent

Your Child's Health History

Please check (✓) all symptoms your child has had, even if they do not seem related to your current problem.

☐ Headaches	☐ Bed Wetting	☐ Frequent Colds	☐ Asthma
☐ Hyperactivity /ADD/ ADHD	☐ Allergies	☐ Irritability	☐ Breathing Problems
☐ Attention Problems	☐ Colic	☐ Skin Problems	☐ Sleeping Problems
☐ Constipation	☐ Ear Infections	☐ Tubes in Ears	☐ Digestive Problems
☐ Vision Problems	☐ Moodiness/ Mood swings		

☐ Other: _____

Mother's Pregnancy & Labor

Child's Current Health Status

Why this section is important: At South Shore Family Chiropractic, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you and your child have faced, allowing us to better assess the challenges to your health potential.

Please answer the following questions the best you can:

Did your child experience any physical injures? (falls, car accidents, etc)	Yes	No	Unsure	Did you suffer traumas (physical or emotional) during pregnancy?	Yes	No	Unsure
Is your child "accident prone"?	Yes	No	Unsure	Was your delivery chemically induced, C-section, forceps or vacuum assisted?	Yes	No	Unsure
Did/does your child play youth sports?	Yes	No	Unsure	Did / do you nurse the baby? If Yes, for how long? _____	Yes	No	Unsure
Has your child fallen/jumped from a height over three feet? (i.e. crib, bunk bed , trees)	Yes	No	Unsure	Did / does your baby have colic?	Yes	No	Unsure
Did/does your child have difficulty interacting with others?	Yes	No	Unsure	Have you noticed any nervousness, twitches, shakes or rocking?	Yes	No	Unsure

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Goals for Child's Care

People see Chiropractors for a variety of reasons. We will weigh your needs and desires when recommending your care plan. Please check ☐ the type of care desired

☐ Relief Care – Symptomatic relief of pain or discomfort.

☐ Corrective Care – Correcting and relieving the cause of the problems as well as the symptoms.

☐ Comprehensive Care – Bring whatever is malfunctioning in the body to the highest state of health possible.

☐ I want the Doctor to select and recommend the type of care appropriate for my child.

Name_____ Date: _____/_____/_____

FAMILY HEALTH HISTORY

Please review the listed diseases and conditions and indicate those that are **current** health problems of a family member by the designation **C** under his/her column. The designation **P** should be used to indicate a **past** problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

	FATHER	MOTHER	SPOUSE	SIBLING	SIBLING	SIBLING	CHILD	CHILD	CHILD
	Age:	Age:	Age:	Age:	Age:	Age:	Age:	Age:	Age:
CONDITION									
Arthritis									
Asthma/Hay Fever									
Back Trouble									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc Problems									
Emotional Problems									
Emphysema									
Epilepsy									
Headaches									
Heart Trouble									
High Blood Pressure									
Insomnia									
Kidney Trouble									
Liver Trouble									
Migraine									
Nervousness									
Neuritis									
Pinched Nerve									
Scoliosis									
Sinus Trouble									
Stomach Trouble									
Syphilis									
Other									

If any of the above family members are deceased, please list their age at death and cause:_____

_____

_____

Patients Signature _____

Name _____ Date: _____/_____/_____

Payment and Insurance Information

Payment is expected at the time of each visit.

I agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am responsible for any and all services covered and non-covered. I also understand that if I terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I authorize the doctor and his/her staff to release and information deemed appropriate concerning my medical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered. I hereby release him her of any consequence there of. I agree that a photocopy of the dimensional serve as the original.

I hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that for a copy of this agreement shall serve as the original.

I understand that payment is expected at the time of service. I choose to pay by:

___ Cash/Check ___Credit Card ___Group Health Insurance

___Worker's Compensation ___Auto Insurance ___Medicare

___Medicaid ___Other:_____

Patient Signature: _____Date: _____/_____/_____

(If you are under 18 years of age, we need a parent or guardian signature authorizing us to treat you.)

Parent/Guardian Signature: _____ Date: _____/_____/_____

Please fill in information as <u>completely</u> as possible so insurance claims are <u>accurate</u>.

Name of policy holder _____ Relationship to patient _____

Policy holder's address (if different from patient's)_____

Phone# _____ Date of birth _____ SS# _____

Policy holder's employer (and address) _____

_____

Insurance Company _____ Insured's ID number _____

Insurance Company's address _____

_____

Insurance Company's Phone # _____ Fax# _____