Essential Family CHIROPRACTIC

PEDIATRIC PRACTICE MEMBER APPLICATION

Practice Member Name: _____ Today's Date: _____/_____/_____

Parent Name(s): _____ Email: _____

Date of Birth: _____/_____/_____ Age: _____ Male / Female

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

Cell Phone: _____ Home Phone: _____

Preferred Method of Communication (check one): □ Email □ Text □ Cell Phone □ Home Phone

Who may we thank for referring you? _____

WHAT BRINGS YOU IN TODAY? PLEASE LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1.					
2.					
3.					
4.					
5.					

HAVE YOU SEEN ANY MEDICAL DOCTORS FOR THESE CONDITIONS? YES / NO

IF YES, WHEN? _____

HAVE YOU PREVIOUSLY SEEN A CHIROPRACTOR? YES / NO DATE OF LAST SPINAL XRAYS: _____

IF YES, WHO AND WHEN WERE YOU LAST ADJUSTED? _____

LIST ALL SURGICAL OPERATIONS AND YEARS:

_____

_____

LIST ALL OVER THE COUNTER & PRESCRIPTION MEDICATIONS YOU TAKE / LAST ROUND OF ANITBIOTICS (DATE)

_____

_____

LIST ALL TRAUMAS (TRIPS, SLIPS, FALLS, SPORTS, EXERCISE, AUTO ACCIDENTS) AND DATES:

_____

_____

HAVE YOU EVER BEEN KNOCKED UNCONCIOUS? YES / NO **FRACTURED A BONE? YES / NO**

IF YES, PLEASE DESCRIBE: _____

CIRCLE ANY CONDITION YOU HAVE / HAVE HAD:				
CANCER	**SEIZURES**	**SPINAL SURGERY**	**DIABETES**	**SCOLIOSIS**

CIRCLE ALL *CURRENT* PROBLEMS:

DIZZINESS	ASTHMA	HEART DISORDERS	CONSTIPATION	NECK PAIN
HEADACHES	ALLERGIES	BREATHING PROBLEMS	DIARRHEA	MID BACK PAIN
EPILEPSY/SEIZURES	EAR INFECTIONS	TROUBLE SLEEPING	FOOD SENSITIVITY	LOW BACK PAIN
NERVOUSNESS	FREQUENT COLDS	BEHAVIORAL CONCERNS	BED WETTING	POOR POSTURE
NAUSEA	HIGH FEVERS	TROUBLE CONCENTRATING	MUSCLE SPASMS	NUMBNESS
ADD/ADHD	ECZEMA/RASH	COLIC/ACID REFLUX	MUSCLE WEAKNESS	LEG PAIN

BIRTH & CHILDHOOD HISTORY

Any complications during birth or mother's pregnancy?	**YES / NO**	Details:			
Type of delivery:	**C-Section**	**Vaginal**	How long was labor and delivery?		
What did the care provider use to assist in delivery?	**Hands**	**Vacuum**	**Forceps**	**Unassisted**	
Were you vaccinated?	**YES / NO**	List any reactions/injuries (ex: fever):			
List any over-the-counter or prescription medications frequently used as a child	**YES / NO**	Details:			
Did your parents worry often about your health?	**YES / NO**	Due to health issues, did you miss school and other activities?	**YES / NO**	Details:	

FAMILY HISTORY

CONDITION	MOTHER	FATHER
Arthritis		
Asthma/Allergies/Sinus Trouble		
ADD/ADHD		
Bed Wetting		
Cancer		
Carpal Tunnel		
Deceased		
Diabetes		
Digestive Problems/Heartburn		
High Blood Pressure		
Fibromyalgia		
Headaches/Migraines		
Neck Pain/Back Pain/Disc Problems		
Menstrual Problems		
Scoliosis		