

Child's Name: _____ Today's Date: _____

Address: _____

 Telephone #s: (hm) _____
 (wk) _____
 (cell) _____
 (cell) _____
 (fax) _____
 Family email address: _____
 Parent's Name: _____
 Parent's Employer: _____
 Parent's Name: _____
 Parent's Employer: _____

Date of Birth: _____
 Gender assigned at birth: M F
 Preferred gender identity now: _____

 What is the cause of the child's symptoms?
 A vehicle crash? Y N
 What state? _____
 Home accident? Y N
 Other accident? Y N
 Illness? Y N
 Unknown? Y N

How did you hear about our office? _____

Does your child have any previous chiropractic experience? Y N If so, please tell us if you were satisfied with their care Y N , and when (approximately) was their most recent adjustment _____?

Does your child see a primary care physician or medical specialist regularly? Y N If so, please list their names and specialties, and the approximate date of the last visit. _____

How many prescription and over the counter medicines is your child currently taking? _____ Who is monitoring their use of these medicines? _____

Please list any condition that the doctor here should be aware of: _____

Has your child ever been treated on an emergency basis anywhere, for any reason? Y N Please explain: _____

Please list all surgeries your child has had: _____

Are there any other health issues are you interested in exploring with the doctor here? Please circle all that apply.
VACCINATIONS NUTRITION DIETARY SUPPLEMENTS IMPROVED IMMUNITY INFERTILITY LIFESTYLE ALLERGIES
ADD/ADHD OTHER _____

Child's Name: _____ Today's Date: _____

****Please fill out this page for children 10 and under only****

Any problems or complications during pregnancy? _____

Name & credentials of birth professional(s): _____

Location of birth: _____

Type of delivery (please circle all that apply): VAGINAL FORCEPS BREECH CESAREAN MULTIPLE EMERGENCY
OTHER _____

Any problems or complications during labor and delivery? _____

APGAR scores: _____/_____ Presence of Jaundice? Y N Presence of Cyanosis? Y N

Birth Weight ___lbs. ___oz. Current Weight ___lbs. ___oz.

Birth Length _____" Current Length _____"

of siblings _____ Birth Order _____

Congenital anomalies/defects known: _____

Vaccinations (circle all that apply):
NONE.....I DON'T INTEND TO HAVE MY CHILD VACCINATED
NONE SO FARI AM UNDECIDED ABOUT THIS ISSUE
PARTIAL.....MY RESEARCH LEAD ME TO LEAVE OUT SOME OF THE VACCINES
PARTIAL.....I JUST HAVEN'T HAD A CHANCE TO CATCH UP YET
COMPLETEUP TO DATE ON ALL RECOMMENDED VACCINES
I WOULD LIKE MORE INFORMATION ABOUT THIS ISSUE.

My child has had the following diseases: _____ At what age? _____

- Chicken Pox _____
- Rubeola _____
- Rubella _____
- Measles _____
- Scarlet Fever _____
- Mumps _____
- Whooping Cough _____
- Otitis Media _____
- Other _____

Any other conditions that the doctor should know about? _____

At what age did your child first:

respond to sound _____	creep _____
track with eyes _____	crawl _____
hold head up _____	pull up _____
sit up alone _____	stand alone _____
roll over _____	walk alone _____
complete potty training _____	

What is the purpose of this visit? _____

Child's Name: _____ Today's Date: _____

The Doctor-Patient Relationship

Informed Consent

Please discuss any questions that this agreement brings up with a doctor before signing.

Chiropractic health care seeks to restore health through natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize its innate healing powers and heal itself.

A Doctor of Chiropractic conducts a clinical analysis for the purpose of determining whether there is evidence of Vertebral Subluxation Complex (VSC). Chiropractic adjustments and ancillary procedures may be administered in an attempt to restore spinal integrity. Due to the complexities of the human body and nature, no doctor can promise specific results. You should be mindful of your child's symptoms and you should seek other opinions if you have any concerns as to the nature of his or her total condition. You are always responsible for the decisions which concern your child's health.

In coming to this office and signing this form, you have granted all of the Doctors of Chiropractic at The Human Joint, and any qualified visiting Doctor of Chiropractic, permission and authority to examine and treat your minor child. You authorize the performance of chiropractic adjustments and other chiropractic procedures, as well as various modes of adjunctive therapy on your child. The chiropractic adjustment and other clinical procedures are usually beneficial and seldom cause any problem. However, in rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The Doctor of Chiropractic will not render a chiropractic adjustment or other procedures if they are aware that such care may be contra-indicated. The doctors will not be responsible for any pre-existing medically diagnosed condition or for any medical diagnosis of which they have not been made aware. We also want you and your child to be comfortable. Therefore, if you would like the doctor to stop, for any reason, at any point during examination or treatment, please say so.

I have read, and I understand the above statement of Informed Consent.

Signed: _____

Date: _____

For minor child: _____

Financial Agreement

Please discuss any questions that this agreement brings up with a doctor before signing.

I agree that I am responsible for all expenses incurred by my child at The Human Joint. If I have insurance, ***I understand that the insurance benefits exist as part of a contract between me and my insurance company,*** and that The Human Joint may provide insurance paperwork as a convenience to me. As a part of this service, The Human Joint may call my insurance company to attempt to obtain information about policy terms and coverage for chiropractic care. I understand that, despite this service, it is possible that inaccurate information may be given by my insurance company regarding my policy terms and coverage for chiropractic care. If proper insurance verification procedures are followed, I will not hold The Human Joint responsible for inaccurate information given by my insurance company.

With this signature, I hereby commit to pay for all services at the time they are rendered.

I have read, and I understand the above Financial Agreement.

Signed: _____

Date: _____

For minor child: _____

The Human Joint

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