New Patient Application - Child

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

Name:_____ Today's Date:_____

Preferred Name: _____ Birthdate: ____/____/____ Age:_____

Address:_____

City/State/Zip:_____ Social Security #:_____

Who may we thank for referring you? _____

Siblings: Yes No

Name: _____ Age:_____

Name: _____ Age:_____

Name: _____ Age:_____

Name: _____ Age:_____

Parents Name: _____ Social Security #:_____

Phone: Home:_____ Work:_____ Cell:_____

Emergency Contact: _____ Phone: _____ Other: _____

Favorite hobbies or interests: _____

Child's Prior Doctor of Chiropractic: _____

City, State: _____ Approximate date of last Chiropractic treatment: _____

Chiropractic adjusting techniques you've had success with: _____

Pediatrician's name: _____

Phone:_____ City, State: _____

Please rate 1 (poor) to 10 (excellent) the quality of healthcare you feel you receive from your GP:

_____

Other Specialists you are currently under care with:

Name: _____ Phone:_____

Name: _____ Phone:_____

Method of payment for first visit

____ Cash ____ Check ____ Credit Card

Person Responsible for payment:

Name: _____

Phone Number:_____

Address: _____

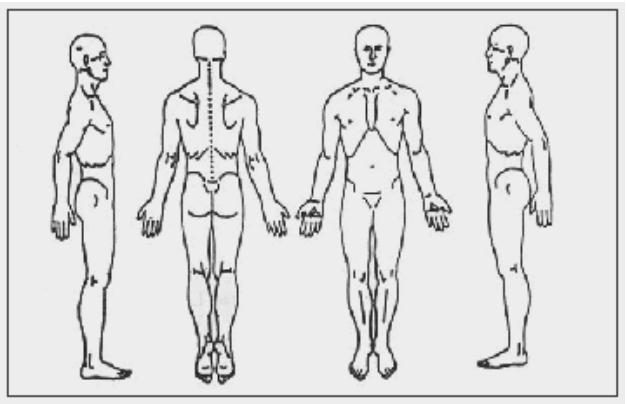
City:_____

State/Zip:_____

Do you have Health (crisis) Insurance? Y N

Insurance Company: _____

Mark Area(s) of Health Concerns:



Health reasons for consulting our office:

1._____ 2. _____

3._____ 4. _____

Has the child had the same or similar problem(s) before? ___Yes ___No

How long?_____ Please explain:_____

_____

Does this condition interfere with: ____school _____sleep ____ daily routine
Father/Mother/Brother/Sister, with similar problems?

_____

Is this the result of an auto injury: If so, when? _____

Other doctors who have treated this problem: _____

What treatments did your child receive: _____

Medication(s) your child currently takes: _____

_____

Does your child take supplements? Yes or No If yes, please list_____

For Menstruating Female Patients. Is there any chance your child is pregnant? Yes____ No ____

What do you understand chiropractic care to be?_____

Do you know what a subluxation is? Yes or No If yes, please describe:

_____

Does your child play any sports or exercise regularly? Yes or No If yes please describe_____

_____

Did the mother have an ultrasound during this pregnancy? _____ Frequency _____

Place of Birth: Home / Birth Center / Hospital Type of Birth: Vaginal / C-section

Was anesthesia used? ___Spinal ___ Epidural ___ Other Was Labor induced? Y / N Why: _____

What position was the child delivered: Squatting / On Back

Birth Trauma: Doctor assisted – twisting, pulling Vacuum Extraction / Forceps

Newborn Trauma (medical procedures and tests):_____

Did your child breast-feed? Y N How Long_____

Please describe any injuries, falls or traumas: _____

Do you or have you had any of the following? Please write *C* of current and *P* for Past

___Angina ___Arthritis ___Asthma ___Allergies ___Bed wetting ___Cancer ___Colic ___Colds ___Diabetes ___Ear infections

___"Growing pains" ___Headaches ___Heart Disease ___Kidney Disease ___Learning disorders ___Migraines

___Numbness/tingling ___ Sciatica ___Seizures ___Sinus Problems ___Spinal curvature ___Stroke ___Thyroid disorder ___Ulcers

Other Medical diagnoses or anything else you are concerned about: _____

_____

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Parent or Guardian Signature: _____

Date: __/__/__

Office: (757) 399-4700 *Fax: (757) 399-0011*

OLDE TOWNE FAMILY CHIROPRACTIC

Patient Authorization regarding chiropractic care provided in an "education driven" environment

It is the practice of this office to provide chiropractic care in an "education driven" environment. Education driven adjusting involves a learning environment for a community of patients being cared for in a common adjusting room. Patients are within sight and hearing range of one another thus profoundly deepening the competency of how your ability to learn can enhance your recovery. A private or confidential setting is always available and accessible should such a less recovery centered and more exam or history driven exchange be necessary.

We provide the ability to protect you from "incidental disclosures" of health information by reminding you that if you wish to speak on private matters we may request a separate though less educationally productive and beneficial setting. Research has proven that the leading cause of death in the world is poorly made decisions. For this reason, even though it is more demanding upon the doctors and staff, we uphold the disciplines to function in this educationally driven setting so you can hear and learn from more exchanges and examples of ideal health care. In many instances, it is evident that doctors need to educate people may quite possibly be more important than caring for them if we are truly dedicated to making sustainable advances in healthcare.

Please grow your deliberateness at keeping your ears and eyes open and engaged with what every doctor and patient is asking and responding to. These actions will help you get well faster, stay well longer, stop perpetuating previous habits which may have been counterproductive to true health care and more.

Your signature indicates your understanding of this more deliberate and advanced approach to your appointments.

_____

Name (Printed) Signature Date

Cancellation/No-Show Policy for Massage Therapy/Muscle Work

It is the policy of this office that if you find it necessary to cancel or change an appointment you must allow at least 24 hours prior notice. Missed and canceled appointments without proper notification will result in a $30.00 cancellation fee.

If you are late for an appointment, it is necessary to still end at the appointed hour, so not to affect the appointment following you.

_____

Signature Date

Office: (757) 399-4700 *Fax: (757) 399-0011*