ALISO FAMILY CHIROPRACTIC

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INITIAL VISIT PAPERWORK FOR CHILDREN 2 YEARS AND UNDER

PERSONAL INFORMATION

Child's Name:_____ DOB:_____ Gender:_____

Parent/Guardian Name:_____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (____)_____ Email: _____

Parent/Guardian Name:_____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (____)_____ Email: _____

INSURANCE INFORMATION

Carrier's Name:_____ Address:_____

City:_____ State:_____ Zip:_____

Phone: (____)_____ Name of Insured:_____

Relationship to you:_____ Policy Holder:_____

Policy/Certificate #:_____ Group #:_____

POLICY STATEMENT

Patients that wish to use health insurance understand all health services furnished are charged directly to the patient and that he/she is ultimately responsible for payment of all services. Our office will help prepare the patient's insurance forms to assist in collecting reimbursements from insurance companies. However, we cannot render services on the assumption that our charges will be paid by an insurance company. I have read the above and understand the office policy. I hereby authorize treatment.

Signature of guardian for patient under 18 years of age:_____

Date:_____

ALISO FAMILY CHIROPRACTIC

What is your child's chief complaint today? _____
_____
When did your child's symptoms start? _____
Have they had this problem in the past?: ( ) Yes ( ) No If so, explain: _____
_____
What aggravates their condition? _____
What provides them with relief (if any)? _____
Is this condition getting progressively worse? ( ) Yes ( ) No ( ) Same
Have they seen any other doctors for this condition? _____
Have they ever been treated by a chiropractor before? ( ) Yes ( ) No

COMPLETE THIS SECTION FOR CHILDREN UNDER 1 YEAR OF AGE

Was your baby breastfed? ( ) Yes ( ) No How long? _____
Does your baby favor one breast over the other? ( ) Yes ( ) No ( ) Left ( ) Right
Does your baby have any of the following:

- ☐ Colic
- ☐ Reflux (projectile or spit up)
- ☐ Head rotated and/or tilted to one preferred side
- ☐ Difficulty latching
- ☐ Trouble sleeping
- ☐ Crying more than usual
- ☐ Allergies to:_____

Is your baby taking any medications? ( ) Yes ( ) No If so, which ones?:_____
_____
Did your baby receive any vaccinations? ( ) Yes ( ) No
Is your child crawling? ( ) Yes ( ) No If so, at what age? _____

MOTHER'S HISTORY

Did you have any problems during pregnancy? ( ) Yes ( ) No If so, explain: _____
_____
Did you receive chiropractic care during your pregnancy? ( ) Yes ( ) No
Baby was born at how many weeks? _____
Born vaginally ( ) or by cesarean ( )?
How many other children do you have? _____
How long was your labor? _____
Were you artificially induced? ( ) Yes ( ) No
Did you have an epidural? ( ) Yes ( ) No
Did you have any complications after delivering? ( ) Yes ( ) No If so, what were they?:_____
_____
_____

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COMPLETE THIS SECTION FOR CHILDREN BETWEEN THE AGES OF 1 AND 2 YEARS OLD

Child crawling? ( ) Yes ( ) No If so, at what age? _____
Child walking? ( ) Yes ( ) No If so, at what age? _____
Did you notice anything unusual about the child's efforts when learning to walk?
( ) Yes ( ) No If so, explain: _____
Did your child have any particularly hard falls that you recall? ( ) Yes ( ) No
If so, explain: _____
Does your child have any of the following:

- □ Ear infections
- □ Sinus trouble
- □ Digestive issues
- □ Attention issues
- □ Irritability
- □ Trouble sleeping
- □ Allergies to: _____
- □ Pain location_____
- □ Previous fractures? Explain:_____

Is your child taking any medications? ( ) Yes ( ) No If so, which ones _____
_____
Did your child receive any vaccinations? ( ) Yes ( ) No
Has your child been diagnosed with any diseases? ( ) Yes ( ) No If so, explain: _____
_____

CONSENT TO TREATMENT OF MINOR

I (We) being the parent or guardian of _____, a minor, the age of _____ do hereby consent Dr. Wang or Dr. Clark to administer such treatment deemed advisable, necessary or requested on the above minor.

I (We) agree to hold him/her free and harmless from any claims, suits for damages or complications which may result from such treatment.

Parent/Guardian Name (please print) _____
Relationship to Patient: ( ) Parent/Guardian ( ) Other _____

Parent/Guardian Signature _____
Date:_____

Witness:_____