

Welcome To Johnson Family Chiropractic Pediatric Patient Form

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

CHILD INFORMATION:

Name	Preferred Name	Date of Birth	Social Security Number			
Address	City	State	Zip	Home Phone	Age	Sex

PARENT INFORMATION:

Name		Preferred Name	Referred by		Home Phone
Address			Occupation		Cell Phone
City / State / Zip			Employment		Work Phone
Age	Sex	Date of Birth	Marital Status		# of Children
Social Security Number		Driver's License #	Spouse's Name		Spouse's Date of Birth
Spouse's Occupation		Spouse's Employer	Spouse's Social Security Number		
Emergency Contact (Name, relation & home & work numbers)					E Mail

INSURANCE INFORMATION:

Insurance Company (Primary)		Company Address (Primary)			Is this Your Employer's Plan?
Insured Person	Insured DOB	Relationship to Insured	ID Number	Group Number	
Insurance Company (Secondary)		Company Address (Secondary)			Is this Your Employer's Plan?
Insured Person	Insured DOB	Relationship to Insured	ID Number	Group Number	

EXPERIENCE WITH CHIROPRACTIC

Has your child ever been adjusted by a chiropractor? Yes No Doctor's Name _____

Has any adult in your family seen a chiropractor? Yes No Doctor's Name _____

Has any other child in your family seen a chiropractor? Yes No Doctor's Name _____

CHILD HEALTH HISTORY

Allergies	Breathing Problems	Ear Problems / Tubes in ears	Skin Problems
Asthma	Colic	Frequent Colds	Sleeping Disorders
Attention Problems	Constipation	Headaches	Vision Problems
Bed Wetting	Digestive Problems	Hyperactive / Irritability	Other

CHILD HEALTH INFORMATION

Has your child been vaccinated? Yes No

Has your child ever taken antibiotics? Yes No

Has your child ever been hospitalized? Yes No

Has your child ever had a severe fall? Yes No

Has your child ever been in a car accident? Yes No

Is your child accident prone? Yes No

Has your child ever had surgery? Yes No What kind: _____

REASON FOR VISIT:

Please describe the reason for this visit : _____

How long has your child had this condition? _____

Has this condition: Gotten Worse Stayed The Same Comes And Goes

Does this condition interfere with : Daily Routine Sleep Other Activities _____

Has this condition occurred before? Yes No When _____

Have you seen other doctors for this condition? Yes No Who _____ When _____

MOTHER’S PREGNANCY AND LABOR

During Pregnancy: Drugs /Medicine Used Tobacco /Alcohol Consumed Illness during pregnancy _____

Labor & Delivery: (Please check all that apply)

Labor Chemically Induced Labor Was Dr. Assisted C- Section Delivery Premature Delivery

Forceps /Vacuum Extraction Did Dr. Pull Or Twist Baby All Natural Delivery

Did you nurse the baby? Yes No

Did your baby have colic? Yes No

Did your baby have feeding problems? Yes No

ARE YOUR CHILD’S SYMPTOMS WORSE WITH ANY OF THE FOLLOWING? (PLEASE CIRCLE)

DAILY ACTIVITIES	CAN DO	LIMITED	UNABLE TO PERFORM	
Bending	No Effect	Mild	Moderate	Severe
Computer Use	No Effect	Mild	Moderate	Severe
Bathing	No Effect	Mild	Moderate	Severe
Walking	No Effect	Mild	Moderate	Severe
Eating	No Effect	Mild	Moderate	Severe
Sports	No Effect	Mild	Moderate	Severe

On the following scale circle how your child’s condition affects them:

0	1	2	3	4	5	6	7	8	9	10
No pain			Moderate pain				Unbearable pain			

GOALS FOR MY CHILD’S CARE

Based on what you currently know about health and wellness, are you interested in a care plan based solely on:

1. Pain Relief / Temporary Relief (Help the symptoms but does not fix the cause of the problem)
2. Corrective Care (Correct the cause of the problem for maximum stability in the future)
3. Wellness Care

Each care plan focuses on goals that require varying lengths of time and amount of patient participation.

Anything that you would like to add:

PLEASE FEEL FREE TO DISCUSS OUR FEES. FEES ARE PAYABLE WHEN SERVICES ARE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE IN ADVANCE.

Signature _____