

Patient Introduction Card

No. _____ Date: _____

Name (Mr. Mrs. Miss Ms.): _____ Home Phone: (____) _____

Email Address (ex: name@email.com): _____ Cell Phone: (____) _____

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

Married Single Other: _____ Age: _____ Date of Birth: ____ / ____ / ____

Occupation: _____ Employer: _____

Office Address: _____ Office Phone: (____) _____

Previous Chiropractic Care? YES NO If YES, Doctor's Name: _____

Name of your Insurance Company: _____

Major Complaint: _____ Social Security No: _____

Who (or what source) referred you? _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged.



PEDIATRIC HISTORY FORM



Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____ S.S.#: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Birth Date: _____ / _____ / _____ Work Phone: _____

Sex: _____ Weight: _____ Height: _____ Referred By: _____

Names of Parents / Guardians: _____

Purpose For Contacting Us ? _____

Other Doctors Seen for this Condition: _____ N _____ Y , Doctors' Names and Prior Treatments: _____

Other Health Problems ? _____

Check any of the Following Conditions Your Child has Suffered from During the Past Six Months:

- | | | | | |
|---|---|---------------------------------------|---|---|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Asthma / Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Growing / Back Pains |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Other _____ |

Family History: _____

Previous Chiropractor: _____

Date of Last Visit: _____ / _____ / _____ Reason: _____

Name of Pediatrician: _____

Date of Last Visit: _____ / _____ / _____ Reason: _____

Are You Satisfied with the Care Your Child has Received There ? _____ N _____ Y

Number of Doses of Antibiotics Your Child has Taken:

During the Past Six Months: _____ , Total During His / Her Lifetime: _____

Number of Doses of Other Prescription Medications Your Child has Taken:

During the Past Six Months: _____ , Total During His / Her Lifetime: _____ List: _____

Vaccination History: _____

Prenatal History:

Name of Obstetrician / Midwife: _____

Complications During Pregnancy ? _____ N _____ Y , List: _____

Ultrasounds During Pregnancy ? _____ N _____ Y , Number: _____

Medications During Pregnancy / Delivery ? _____ N _____ Y , List: _____

Cigarette / Alcohol Use During Pregnancy: _____ N _____ Y

Location of Birth: _____ Hospital _____ Birthing Center _____ Home

Birth Intervention: _____ Forceps _____ Vacuum Extraction
_____ Ceasarian Section , Emergency or Planned ?

Complications During Delivery ? _____ N _____ Y , List: _____

Genetic Disorders or Disabilities: _____ N _____ Y , List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____ , _____

Feeding History:

Breast Fed: _____ N _____ Y , How Long: _____

Formula Fed: _____ N _____ Y , How Long: _____ Type: _____

Introduced to Solids at: _____ Months , Cows' Milk at _____ Months

Food / Juice Allergies or Intolerances: _____ N _____ Y , List: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to Sound	_____ Cross Crawl
_____ Respond to Visual Stimuli	_____ Stand Alone
_____ Hold Head Up	_____ Walk Alone
_____ Sit Up	

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child ? _____ N _____ Y

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.) ? _____ N _____ Y , List: _____

Has Your Child Ever Been Involved in a Car Accident ? _____ N _____ Y , List: _____

Has Your Child Been Seen on an Emergency Basis ? _____ N _____ Y , List: _____

Other Traumas Not Described Above ? _____ N _____ Y , List: _____

Prior Surgery: _____ N _____ Y , List: _____

Menarche: _____ N _____ Y , Age: _____

Childhood Diseases:

Chicken Pox	N / Y, Age _____	Mumps	N / Y, Age _____
Rubella	N / Y, Age _____	Whooping Cough	N / Y, Age _____
Rubeola	N / Y, Age _____	Other	N / Y, Age _____

**WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.**

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company: _____ Policy #: _____

Signed: _____ Witnessed: _____ Date: ____ / ____ / ____

AUTOMOBILE ACCIDENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Patient _____ Date _____
Sex _____ Marital Status _____ No. _____
Date of Birth _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Occupation _____
Who referred you to our office? _____
Social Sec. # _____ Business Phone _____ Company Name _____
Company Address _____
Please explain in detail how your accident happened? _____

Driver of other vehicle (if any) _____ Date of Birth _____
Insurance Company _____ Address _____ Phone No: _____
Policy No. _____
Claim No. _____
Name of person who has made contact with you _____
Name of driver of vehicle in which you were injured (self or other) _____
Insurance Company _____ Address _____ Phone No: _____
Policy No. _____
Claim No. _____

Name of Person who has made contact with you _____
Have you retained an attorney? Yes No Not Yet
If so, his/her name, address & phone # _____

Give time and date present injury occurred _____ AM PM ____/____/____
You were heading? North South East West on _____ (street or highway)

Number of people in your vehicle _____
Were police notified? Yes No Did head strike windshield or object? Yes No
Were you knocked unconscious Yes No If so, for how long _____
You were struck from? Behind Front Left Side Right Side
You were? Driver Passenger Front seat Back seat Using seat belts Other protective devices
Did you feel pain immediately after the accident? Yes No Later that day Next day When _____

Where did you feel pain immediately after the accident? _____
Where were you taken after the accident? _____
Was treatment given? _____

Was any doctor consulted after the accident? Yes No
If so, give doctor's name _____ D.C., M.D., D.O., D.D.S. _____
Doctor's Diagnosis _____

What treatment was given? _____
How often did you see the doctor? _____
How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? Yes No
If so, what were the complaints? _____

Before the injury, were you capable of working on an equal basis with others your age? Yes No
Are your work activities restricted as a result of this accident? Yes No
Since the injury, are your symptoms Improving? Getting worse? The same?

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: _____

Patient: _____ No.: _____

MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

ARE YOU PREGNANT?

- YES NO

GASTRO-INTENTIONAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

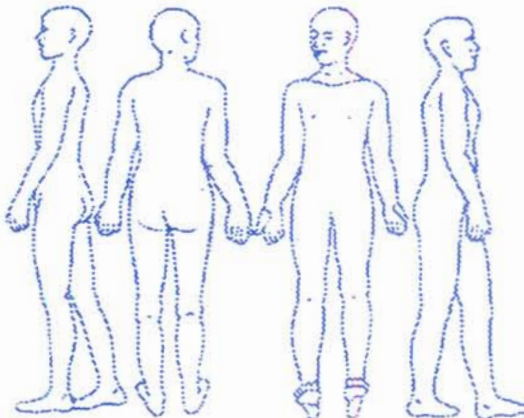
NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Drug Abuse
- _____

SYMPTOM LOCALIZATION



- P ___ Pain T ___ Tender
 N ___ Numb H ___ Hypoesthesia
 S ___ Spasm

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature _____

..... DO NOT WRITE BELOW THIS LINE.....

Patient Accepted? Yes No Doctor's Signature _____