APPLICATION FOR CARE AT NORTHSTAR CHIROPRACTIC

PEDIATRIC PATIENT DEMOGRAPHICS

Childs Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____ Apt#: _____

Mothers(Guardian) Name: _____ Phone: _____ DOB: _____ - _____ - _____

Fathers(Guardian) Name: _____ Phone: _____ DOB: _____ - _____ - _____

Pediatrician/Family MD: _____ Last Visit: _____ Reason For Visit: _____

Who Can We thank For Referring You, Or How Did You Hear About Our Office? _____

Does your child have health insurance: ❑ No ❑ Yes Insurance Company: _____

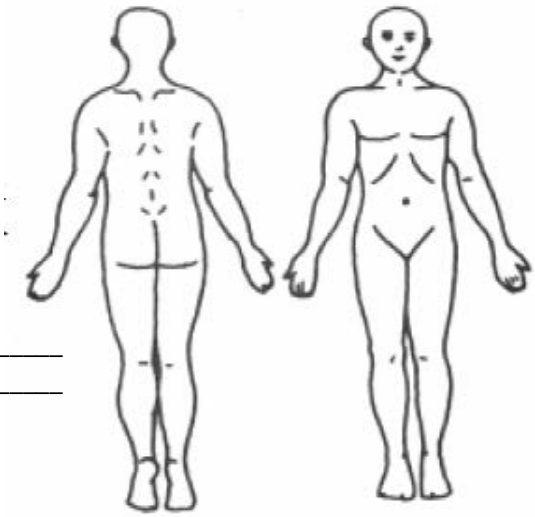
Name of Primary Insured / Policy Holder_____ Their DOB: _____ - _____ - _____

HISTORY OF COMPLAINT(S)

Purpose of Child's Visit: ☐ Pain/Discomfort ☐ Injury/Accident ☐ Wellness Check-Up ☐ Other _____

- When did the problem first begin? _____
- Onset of problem: ☐ Sudden ☐ Gradual ☐ Unknown ☐ Other _____
- Problem occurs: ☐ Constantly ☐ Frequently ☐ Occasionally ☐ Infrequently
- Severity of problem: (No Pain) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (Severe Pain)
- Since this problem began, is it: ☐ Getting worse ☐ Staying the same ☐ Getting better
- When is it the worst? ☐ AM ☐ Mid-day ☐ PM
- Have they ever had this problem before? ☐ No ☐ Yes If Yes, when? _____
- Have they missed or been limited in school, sports or other activities because of this health problem? ☐ No ☐ Yes
- Have they seen other doctors for this problem? ☐ No ☐ Yes If Yes, what did they do?_____

****Please mark on the body diagram with the following letters to describe their symptoms:**
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp **T= T**ingling



What relieves their symptoms? _____

What makes them feel worse? _____

Please list any medications and/or supplements they are taking:

_____

_____

Method of Birth/Delivery: ☐ Vaginal ☐ C-Section ☐ Breech ☐ Traumatic

- Was the use of forceps or suction required? ☐ No ☐ Yes

Have they ever been in an auto accident? ❑ No ❑ Yes If yes, date of the accident: _____
What was the approximate speed of the collision? _____
Type of impact: Front Impact / Side Impact / Rear Impact
Was treatment received? ❑ No ❑ Yes If yes, what: _____

Patient Name: _____ **Date:** _____

HAS YOUR CHILD EVER SUFFERED FROM:

___ Headache	___ Seizures/Convulsions	___ Scoliosis	___ Broken/Fractured Bones	___ Orthopedic Problems
___ Neck Pain	___ Frequent Colds/Flu	___ Colic	___ Rheumatoid Arthritis	___ Fall From Changing Table
___ Dizziness	___ Difficulty Breathing	___ Concussion	___ Behavioral Problems	___ Fall From Bed/Crib/Couch
___ Fainting	___ Asthma	___ ADD/ADHD	___ Trouble Walking	___ Fall From High Chair
___ Chest Pain	___ Sinus Problems	___ Hearing Loss	___ Bed Wetting	___ Fall Down Stairs
___ Back Pain	___ Earaches	___ Allergies	___ Diabetes	___ Fall Off Bike/Skateboard
___ Acid Reflux	___ Trouble Turning Head	___ Anxiety	___ Difficulty Concentrating	___ Fall Off Swing/Monkey Bars
___ Arm Problems	___ Digestive Issues	___ Depression	___ High Blood Pressure	___ Fall Off Trampoline
___ Leg Problems	___ Cancer	___ Poor Sleep	___ Heart Problems	

___ Other Injuries / Illnesses: _____

RELEASE OF INFORMATION:

In accordance with all HIPPA guidelines regarding privacy of patient information and medical records, I understand that my medical information will not be released to anyone without prior written consent. The information listed on these forms are accurate to the best of my knowledge. I authorize utilization of this application or copies thereof for the purpose of processing insurance and medical claims, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability for all uncovered services.

Do you wish to release medical records to any other family members? ❑ No ❑ Yes If yes, who: _____

_____ _____

Parent or Legal Guardian Signature Date

INFORMED CONSENT REGARDING: Chiropractic Exams, Adjustments, Therapeutic Procedures, and X-Rays

Chiropractic care, like all forms of health care, may hold certain risks. Chiropractic treatments are shown to be very safe and effective, and risks are most often minimal, such as muscle soreness following treatments. More significant health risks are extremely rare. I also understand that there are risks with exposure to x-rays. After consideration, I do hereby authorize chiropractic treatments, and/or diagnostic x-ray examinations deemed necessary by the doctor for my minor child for whom I have the legal right to select and authorize health care services on behalf of. If my authority to authorize this care should change in any way due to divorce or other legal proceedings, I will notify this office before treatment is received by my child.

_____ _____

Parent or Legal Guardians Signature Date