Patient Demographics

Name_____Preferred_____Date_____
Address_____ City _____ State_____ Zip_____
Cell Phone _____ Home Phone_____ Gender M F
Date of Birth_____ Age_____ Whom may we thank for your referral_____
Emergency Contact name_____ Emergency Contact number_____
Number of Siblings/Ages_____Height_____Weight_____
Have you ever received Chiropractic Care? Yes No E-mail address _____

Reason for seeking chiropractic care:_____
Other Doctors seen for this condition Yes No Specialty_____
Prior treatment and outcome _____
Other Health Concerns:_____

Symptoms: Please check any current or past problems your child has had on the list below:

___Dizziness	___Runny Nose	___Hyperactivity	___Neck Pain
___ADHD	___Itchy Eyes	___Behavioral	___Arm/Elbow Pain
___Backaches	___Rashes	___Poor Memory	___Leg/Hip Pain
___Heart Condition	___Unusual Moles	___Insomnia	___Knee/Foot Pain
___Chronic Earaches	___Neuritis	___Nightmares	___Growing Pains
___Diabetes	___Digestive	___Bedwetting	___Joint Pain
___Tuberculosis	___Sinus Trouble	___Pain Urinating	___Scoliosis
___Hypertension	___Cough/Wheeze	___Convulsions	___Blood Disorders
___Fever/Chills	___Chest Pain	___Paralysis	___Stomach Pain
___Frequent Colds	___Constipation	___Muscle Pain	___Other:_____
___Arthritis	___Anemia	___Fainting	_____
___Headaches	___Rheumatic Fever	___Broken Bones	_____
___Asthma	___Diarrhea	___Sprains/Strains	_____
___Allergies	___Poor Appetite	___Hernias	

Health History:
Name of Pediatrician_____ Date of Last Visit_____
Reason for visit_____
Medications and conditions being treated_____
Has your child ever taken antibiotics Yes NO Condition Treated:_____
Has your child been injured participating in contact sports (Soccer, Football, Martial Arts….) Yes No
If yes, describe (sprain, broken bone, head trauma…)_____
Has your child ever been involved in a car accident? Yes No Date/Injuries_____
Has your child ever fallen head first from (Changing Table, Bed, Stairs…) Yes No _____
Other Traumas no describes above: Yes No Type/Date_____
Prior Surgery: Yes No Type/Date:_____

Prenatal History:
Location of Birth ____Home ___Birthing Center ____Hospital _____Unknown
Complications during pregnancy: Yes No List:_____
Ultrasounds during pregnancy: Yes No _____
Medications during pregnancy/delivery: Yes No List:_____
Cigarette / Alcohol use during pregnancy: Yes No
Birth Interventions: ___Forceps ___Vacuum ___Caesarian, Why?_____
Complications during delivery: Yes No List:_____
Genetic disorders or disabilities: Yes No List:_____
Birth Weight_____ Birth Length_____ APGAR scores: 1 min_____ 5 min_____

Feeding History:
Breast Fed: Yes No How Long?_____ Formula Fed: Yes No How long?_____ Type:_____
Introduced to solids at ____months, Cow's milk, at _____months
Food / juice allergies or intolerances Yes No List:_____

Developmental History:
Sleep (hrs per night)_____ Naps (number and length)_____ Problems sleeping_____
At what age was your child able to: Crawl_____ Sit alone_____ Stand Alone_____ Walk alone_____ Say words_____

Childhood Dieases:

___Chicken Pox – Age ____	___Meningitis – Age ____	___Whooping Cough – Age ___
___Measles – Age ____	___Rubella – Age ____	___Other – Age _____
___Mumps – Age ____	___Tuberculosis – Age ____	_____

Vaccination History:

___HBV / Hp B	Age____	___IPV (Inactivate Poliovirus) –	Age_____
___DTP or DTap (Diphtheria, Tetanus, Pertussis)	Age____	___MMR (Measles, Mumps, Rubella)	Age_____
___HbCb / HIV (H. Influenzae type b conjugate)	Age____	___Varicella (Chicken Pox)	Age_____
___OPV (Oral Polio Vaccine)	Age____	___PCV (Pneumoccocal)	Age_____

Adverse Reactions to any Vaccine? Yes No
List:_____
_____

Acknowledgements
To set clear expectations, improve communications and help get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initial _____ I instruct the chiropractor to deliver the care that, in his/her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation.

Initial _____ I realize that an x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant.

Initial _____ I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

Initial _____ I agree to pay my office fees, deductibles, co-pays, or other required charges on a per/visit basis unless otherwise arranged with CBC&W. In the event that I become aware of any changes in my insurance information I will notify CBC&W of these changes immediately. I assign benefits paid by my insurance company for services in this office to be paid directly to Cane Bay Chiropractic & Wellness.
*I realize my **insurance does not guarantee payment** for any services rendered at CBC&W and agree to pay all unpaid fees should my insurance policy deny payment**.**

CONSENT TO CHIROPRACTIC CARE

I certify that the information I have supplied is correct and accurate to the best of my knowledge.
I, _____, being the parent or legal guardian of _____,
hereby grant permission for my child to receive chiropractic care.
Signed_____ Witnessed_____

Does anyone else have permission to receive information regarding appointment scheduling or billing information: If so, who?:
_____Relationship_____Phone_____
_____Relationship_____Phone_____
_____Relationship_____Phone_____

Patient Signature_____Date_____

If using insurance, which Insurance Company _____
Carrier's name _____Carriers Date of Birth _____
Carriers relation to patient self / spouse / parent /other _____