



ABOUT THE CHILD

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	
[REDACTED]	
DATE OF BIRTH:	AGE:
SOCIAL SECURITY NUMBER:	
GENDER:	WEIGHT:

ABOUT THE PARENT

PARENT NAME:	
ADDRESS:	
<input type="checkbox"/> SAME AS ABOVE	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
[REDACTED]	
EMPLOYER NAME:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:
[REDACTED]	
INSURANCE COMPANY:	
INSURED'S NAME	
INSURED'S SOCIAL SECURITY NUMBER:	
INSURED'S DATE OF BIRTH	

VACCINATIONS

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED: <input type="checkbox"/> DPT <input type="checkbox"/> MMR <input type="checkbox"/> CHICKEN POX <input type="checkbox"/> HEPATITIS <input type="checkbox"/> OTHER
DESCRIBE ANY AND ALL REACTIONS TO VACCINE (S):

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (ALL THAT APPLY): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:
HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?
HAS ANY CHILD IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> OTHER PLEASE EXPLAIN:
WHEN DID THIS CONDITION BEGIN?
HAS THIS CONDITION: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONDITION INTERFERE WITH: <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS:

MOTHER'S PREGNANCY & LABOR

DURING PREGNANCY DID YOU USE:
 DRUGS/MEDICATIONS TOBACCO/ALCOHOL
 IF YES, PLEASE EXPLAIN:

DESCRIBE YOUR DELIVERY:
 LABOR WAS CHEMICALLY INDUCED LABOR WAS DOCTOR ASSISTED
 C-SECTION DELIVERY FORCEPS/VACUUM EXTRACTION
 DOCTOR PULLED OR TWISTED BABY PREMATURE DELIVERY
 PLEASE EXPLAIN:

DID YOU EXPERIENCE ANY ILLNESS(S) WHILE PREGNANT?
 YES NO
 PLEASE EXPLAIN:

DID YOU NURSE THE BABY? YES NO

DID YOU EXPERIENCE FEEDING PROBLEMS? YES NO

DID YOUR BABY HAVE COLIC? YES NO

VACCINATIONS? YES NO

CHILD'S CURRENT HEALTH STATUS

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS? YES NO
 PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED? YES NO
 PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD A SEVERE FALL? YES NO
 PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT? YES NO
 PLEASE EXPLAIN:

IS YOUR CHILD ACCIDENT PRONE? YES NO
 PLEASE EXPLAIN:

HAS YOUR CHILD EVER HAD SURGERY? YES NO
 PLEASE EXPLAIN:

IS YOUR CHILD CURRENTLY TAKING MEDICATIONS? YES NO
 PLEASE EXPLAIN:

DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS?
 YES NO PLEASE EXPLAIN:

HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR?
 YES NO PLEASE EXPLAIN:

WHAT CHANGES (IF ANY) IN YOUR CHILD'S HEALTH OR BEHAVIOR WOULD YOU LIKE ACCOMPLISHED?

CHILD'S HEALTH HISTORY

INSTRUCTIONS: *Please check each of the diseases or conditions that the child now or had had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.*

<input type="checkbox"/> ALLERGIES	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> IRRITABILITY
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DIGESTIVE PROBLEMS	<input type="checkbox"/> SKIN PROBLEMS
<input type="checkbox"/> ATTENTION PROBLEMS	<input type="checkbox"/> EAR PROBLEMS	<input type="checkbox"/> SLEEPING DISORDERS
<input type="checkbox"/> BED WETTING	<input type="checkbox"/> FREQUENT COLDS	<input type="checkbox"/> TUBES IN THE EARS
<input type="checkbox"/> BREATHING PROBLEMS	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> VISION PROBLEMS
<input type="checkbox"/> COLIC	<input type="checkbox"/> HYPERACTIVITY	<input type="checkbox"/> OTHER:

CHIROPRACTIC AWARENESS

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM? <input type="checkbox"/> YES <input type="checkbox"/> NO	THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS? <input type="checkbox"/> YES <input type="checkbox"/> NO
CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF CHIROPRACTIC CARE STARTS AT BIRTH, YOU CAN ACHIEVE A HIGHER LEVEL OF HEALTH THROUGHOUT LIFE? <input type="checkbox"/> YES <input type="checkbox"/> NO

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care, To work with the condition of my dependant through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered my dependant are charged directly to me and that I am personally responsible for payment. The Dr. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate care for any reason, any fees for professional services rendered will become immediately due and payable.

I am a parent of legal guardian of the above-named minor and I authorize Dr. Keith Morehouse/Dr. Kash Merrill to conduct appropriate examinations of and administer appropriate treatment to him/her.

PARENT OR GUARDIAN AUTHORIZING CARE SIGNATURE:	DATE:
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