Child Welcome Form

Today's Date_____

Name_____ Date of Birth_____ Phone_____
What does your child prefer to be called? _____ Age_____
Address_____ City _____ State_____ Zip_____
Parents Name (s) _____
Who may we thank for referring you to our office? _____
Has your child ever been treated by a Chiropractor before? ( ) Yes( ) No
If yes whom? _____

Insurance Information

Insured's Name _____ Relation_____ Date of Birth_____
Insured's SS# / Member #_____Group # _____ Ins Co._____
Insured's Employer _____ Ins Co. Address _____
Ins Co. Phone #_____ Person Ultimately Responsible for Account (Name and Address) _____

Reason for Visit

The reason for this visit is a result of (Please Circle): Sports Auto Trauma Other
Explain what happened: _____
_____
Drs. Note's _____
_____
_____
Please describe the pain and where it is located: _____
_____
_____
Drs. Note's_____
_____
When did this condition begin? _____
Is this condition getting worse? ( ) Yes ( ) No ( ) Constant ( ) Comes and Goes
Is this condition interfering in (Please Circle): Sleep Daily Routine Play?
Is there a prior history of a problem like this? _____ If yes, dates, prior treatment, results, etc. _____
_____
Drs. Note's _____
_____
Has your child ever been treated by a medical physician for this condition? ( ) Yes ( ) No
If yes, where? _____
For what condition? _____
Please describe any additional complaints: _____
_____
_____
_____

Past Medical History

Has your child had any of the following diseases/ medical conditions?

__ Frequent Neck Pain __ Severe/Frequent Headaches __ Fainting/ Seizures/ Epilepepsy
__ Diabetes/ Tuberculosis __ Lower Back Problems __ Artificial Bones/ Joints
__ Heart Surgery/ Pacemaker __ Mitral Valve Prolapse __ Shingles
__ Psychiatric Problems __ Kidney Problems __ Sinus Problems
__ Difficulty Breathing __ Hypothyroid __ Arthritis

Please list any other serious medical condition(s) that your child has had: _____
_____
Is your child allergic to anything: _____
Please list previous surgeries/ treatment with dates your child has had: _____
_____
List any past serious accidents with dates: _____
Family Health History: _____
_____
Is your child taking any medications or supplements? Please list: _____
_____

Habits & Activities

Does your child regularly exercise? ( )Yes ( ) No Activity and intensity:_____
_____
Does your child eat a well balanced diet? ( ) Yes ( ) No
Are there any particular activities of daily living that your child is difficulty with due to their complaint(s)?_____
Drs. Note's _____
_____
_____

In the Event of Emergency

Who should we contact? _____ Relation_____
Home# _____ Work#_____ Cell#_____
Who is your child's Medical Doctor?_____ Phone#_____

- We invite you to discuss with us any questions you have regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. You are responsible for your child's account balance.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment of my child. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my child's medical status.
- I authorize the doctors of Front Street Chiropractic to diagnose and treat this patient.

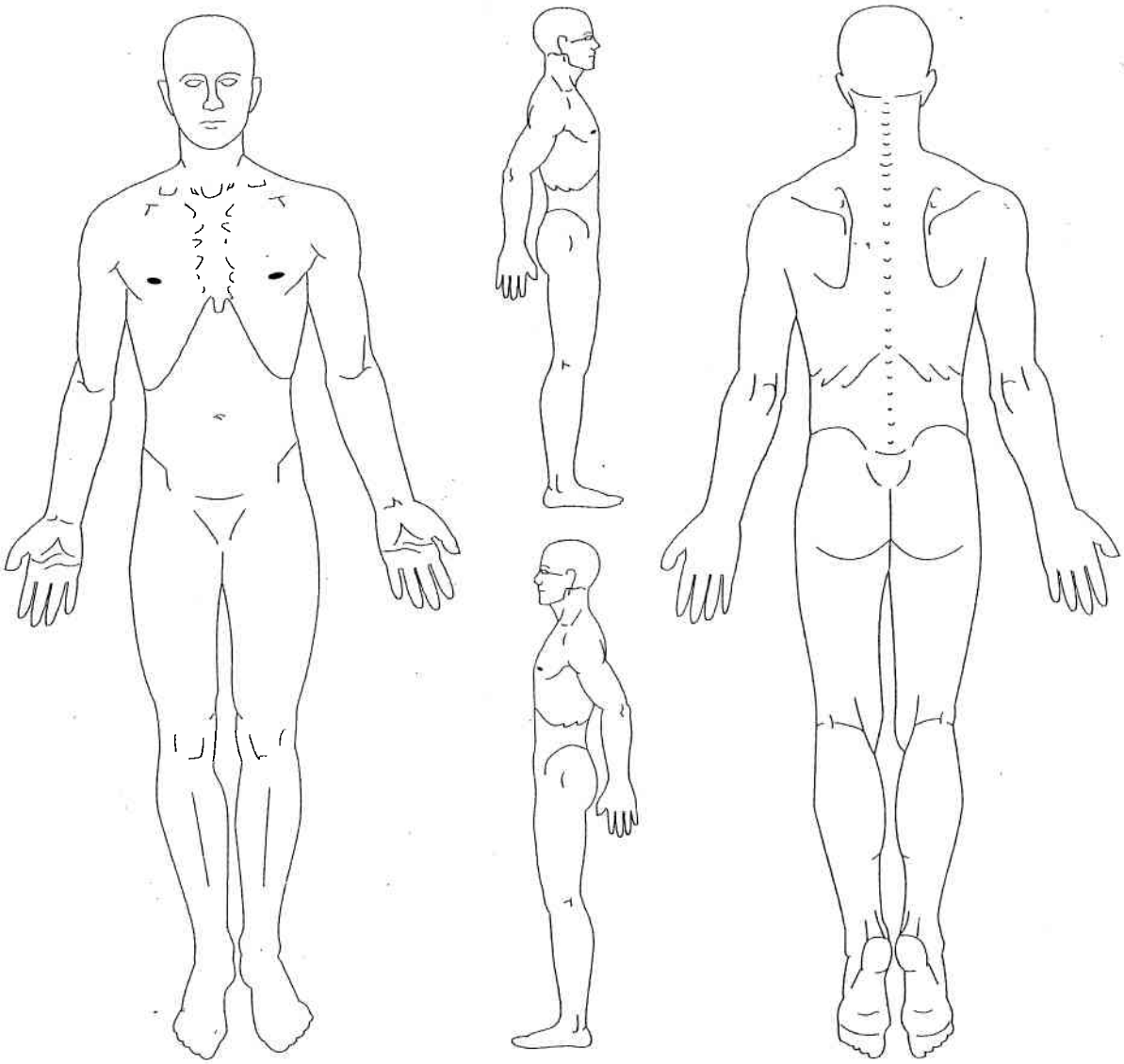
_____ _____ _____
Signature Parent/Guardian Relationship to Child Date

Patient Name(Print) _____ Date _____

Patient ID # _____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
N = Numb
S = Stabbing/Cutting
T = Tingling (Pins & Needles)
C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now:**

No Pain — Unbearable Pain

Rate your pain at its **best** in the past week:

No Pain — Unbearable Pain

Rate your **average** pain in the past week:

No Pain — Unbearable Pain

Rate your **worst** pain in the past week:

No Pain — Unbearable Pain