

KHALSA CHIROPRACTIC

Confidential Patient Information

Today's Date _____

Name of Child _____ Age _____ Birthdate _____

Address _____ City _____ Zip Code _____

Name of Mother _____ Soc. Sec. No. _____

Address _____ City _____ Zip Code _____

Home Phone _____ Work Phone _____

Employer _____ Address _____

Name of Father _____ Soc. Sec. No. _____

Address _____ City _____ Zip Code _____

Home Phone _____ Work Phone _____

Employer _____ Address _____

Name of Insured _____

Who referred you to our office? _____

Has the child ever been under Chiropractic Care? Yes No Name of Doctor _____

Present reason for consulting the office:

Chiropractic Checkup & Spinal Examination

Specific symptom or condition _____

Date symptoms appeared or accident happened _____

Patient ever had same or similar condition? _____

If yes, when? and describe _____

Name of Pediatrician _____ Address _____

Date of last physical examination _____

List any surgeries patient has had _____

Serious Illnesses _____

Serious Accidents _____

Has the child suffered from:

	Never	Rarely	Occasionally	Frequently		Never	Rarely	Occasionally	Frequently
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bed-Wetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeplessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue/Listlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg Pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arm/Shoulder Pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Growing Pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Limping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fevers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Purpose of this appointment (including Major Complaint, if any) _____

What activities aggravate this condition? _____

Is this condition getting worse better staying the same?

Is this condition interfering with school sleep daily routine other activities?

Other doctors seen for this condition _____

List any medications patient is taking _____

List any vitamins or supplements _____

Remarks and additional information _____

Payment is expected at time of visit!

Name of person responsible for payment _____

Is child insured? _____ Company _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount to be paid directly to this chiropractic office will be credited to my child's account upon receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my child's account. However, I clearly understand and agree that all services rendered to my child are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my child's care and treatment, any fees for professional services rendered will be immediately due and payable.

I also hereby authorize treatment of my child in this chiropractic office.

Signature of Parent or Legal Guardian Date