KHALSA CHIROPRACTIC **Child's Confidential Patient Information**

Today's Date_____

Name of Child_____Age_____Birthdate_____

Address_____City_____Zip Code_____

Name of Mother_____Cell Phone_____

Address_____ City_____Zip Code_____

Home phone_____Work phone_____

Employer_____Address_____

Name of Father_____Cell Phone_____

Address_____ City_____Zip Code_____

Home phone_____Work phone_____

Employer_____Address_____

Name of Insured_____Insurance Co._____

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 symptom(s) appeared or accident happened_____

Patient ever had same of similar condition? ☐ No ☐ Yes: If yes, when? And describe_____

_____

_____

Name of Pediatrician_____Address_____

Date of last physical examination_____

Surgeries, Serious Illnesses or Accidents (include date)_____

_____

Has the child suffered from:

	Never	Rarely	Occasionally	Frequently			Never	Rarely	Occasionally	Frequently
Allergies						Bed-Wetting				
Asthma						Digestive Problems				
Headache						Nausea				
Sleeplessness						Tonsilitis				
Dizziness						Colds				
Fatigue/Listlessness						Bronchitis				
Nervousness						Nosebleeds				
Depression						Hyperact5ivity				
Neck Pain/Stiffness						Leg Pains				
Low Back Pain						Arm/Shoulder Pains				
Foot Trouble						Growing Pains				
Sinus Infections						Limping				
Ear Aches						Fevers				

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 interering with ☐ School ☐ Sleep ☐ Daily Routine ☐ Other activities?_____

Other doctors seen for this condition_____

_____

List any medications child is taking_____

_____

List any vitamins or supplements child is taking_____

_____

Remarks and additional information_____

_____

_____

Name of person responsible for payment_____

Is child insured? ☐ No ☐ Yes, Insurance Company_____

I hereby authorize treatment of my child in this office

_____

Signature of Parent or Legal Guardian Date