Welcome! KIDS

Patient Information

Date ________________________________

Please complete this form in ink. If you have any questions or concerns, please ask for assistance. We'll be happy to help. (Please Print)

Child's Name ________________________________ Social Security # _________-_____-_________

Age ______ Date of Birth _____/_____/_____ Sex: □ M □ F Previous Chiropractic Care? □ Yes □ No

Street Address ________________________________ P.O. Box (street address also needed) ______________

City ________________________________ State ________ Zip ______________

Child's School ________________________________ Grade Level ______________

Person to contact in case of emergency ________________________________ Phone (____) ____________

Parent/Gaurdian Information

Names of Parent(s)/Gaurdian(s)________________________________

Street Address (if different from child's)________________________________ P.O. Box ______________

City ________________________________ State ________ Zip ______________

Home phone (____) __________________ Age ______ Date of Birth _____/_____/_____ Sex: □M □F (Parent/Gaurdian)

Name of Employer________________________________ Work Phone (____)___________

How did you hear of Melby Chiropractic? □Website □Newspaper □Mailer □Word of Mouth □Other ____________

Whom may we thank for referring you to us? ________________________________

Insurance Information

Name of Policy Holder________________________________ Relationship to Patient ______________________

Policy Holder's Date of Birth _____/_____/_____ Policy Holder's Social Security # _________-_____-_________

*Please present insurance card to front desk personnel

Health Information

Primary reason for visit: □Wellness care □Other: ________________________________

Date of last physical exam: ________________________________

List any surgeries the child has had and dates:________________________________

Known allergies: ________________________________

Other current health problems or areas of pain:________________________________

Continues on Back→

Check only those conditions that are applicable:

☐Headaches	☐Fatigue	☐Underactivity	☐Colic	☐Asthma
☐Sinus	☐Chicken Pox	☐Frequent Illness	☐Stomach Trouble	☐Rashes
☐Pain/Allergies	☐Irritability	☐Learning Disorder	☐Measles	☐Other__________
☐Ear Infections	☐Diabetes	☐Mumps	☐Whooping Cough	________________
☐Sleeping Problems	☐ Fractures	☐Diarrhea	☐Bed-Wetting	________________
☐Appendicitis	☐Hyperactivity	☐Constipation	☐Poor Diet	________________

How do the above problems affect your child's daily life:

- ☐Restricted in daily activities
- ☐Excessive appetite or thirst
- ☐Hindering ability to exercise or to participate in sports and activities
- ☐Poor posture during reading, watching TV, working on a computer

How long has your child experienced these problems? ________________________________

Over time, the problem is: ☐ Better ☐ Worse

Have you seen any other health care professionals for this condition? ☐ Yes ☐ No

Regarding your child:

Is your child accident prone	☐ Yes ☐ No
Has your child had any falls down steps?	☐ Yes ☐ No
Has your child ever been involved in a motor vehicle accident?	☐ Yes ☐ No
Has your child ever been hospitalized or had surgery?	☐ Yes ☐ No
Has your child ever had any broken bones or sprain injuries?	☐ Yes ☐ No
Is your child currently taking medications?	☐ Yes ☐ No
Does your child carry a heavy backpack?	☐ Yes ☐ No
Do your child's sleeping patterns seem normal to you?	☐ Yes ☐ No
Was / is your child breast-fed?	☐ Yes ☐ No
Has your child been exposed to vaccinations?	☐ Yes ☐ No
Has your child taken any antibiotics?	☐ Yes ☐ No
Does your child have any problems with bonding?	☐ Yes ☐ No
Does your child have any behavioral problems?	☐ Yes ☐ No
Did your child enter daycare at an early age?	☐ Yes ☐ No
Is your child involved in sports?	☐ Yes ☐ No

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health. I certify that my minor child has insurance coverage with _________________________________ (name of insurance co.) And assign directly to Melby Chiropractic Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Melby Chiropractic Clinic may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____ ________________________________

Signature of Parent, Guardian, or Personal Representative Date

____ ________________________________

Please **print** name of Parent, Guardian, or Personal Representative Relationship to Patient