STONE FAMILY CHIROPRACTIC CENTER - Ages 10-17

Thank you for choosing our office to take care of your health needs.
To help us serve you better, please complete the following information.

Today's Date: ____________________

PATIENT INFORMATION

Print Full Name: ____ Name you go by: ____________________

Parent's/Guardian's Names: ____

Street Address: ___________________________________City: _______________ State: _____ Zip: ______

Age: ____ Height: ______ Weight: ______ Date of Birth: ___________ Sex: Male☐ Female☐

Number of siblings ___________ Patient's email address (if applicable) ______________________________

Where did you hear about our office or who referred you? ____

Phone Numbers:

Home: ________________ Parents Work: ________________ ext.____ Parent Cell: ___________________

Parent/Guardian E-mail address: ____

INSURANCE

Do you have medical insurance? Yes☐ No☐ Insurance Company Name: ____________________________

Policy Number: ______________________ Insurance Company Phone Number: _______________________

Insured's Name (if different from patient): ________________________ Relationship to patient: ____________

Insured's Date of Birth: __________________ Insured's Social Security Number: _______________________

HEALTH HISTORY

If you have no symptoms or complaints and are here for wellness services, please check ☐; otherwise briefly describe the reason for seeking chiropractic care: ____

Is this due to an accident or injury? Yes☐ No☐ Date: ________Type of accident: Auto☐ Other: ___________

Does it interfere with your (circle all that apply): Work/School Sleep Daily routine Exercise

Have you seen other doctors for this condition? Yes☐ No☐ Dr's name:______________________________

Please fill in the blanks below describing the chief complaint that you have:

- **How long** have you had the above complaints? ____
- **How often** do you have the above complaints? ____
- Is your pain **sharp, dull throbbing, burning, numb** and/or **achy?** ________________________________
- Is your pain worse in the **morning, evening,** and/or **after a specific activity?** ______________________

- Have you ever experienced (check all that apply):

☐ Headaches/Migraines	☐ Colic/Reflux	☐ Ear Infections	☐ Growing Pains
☐ Dizziness	☐ Poor Appetite	☐ Asthma	☐ Female/Male Problems
☐ Fainting/Seizures	☐ Sugar Cravings	☐ Allergies	☐ Behavioral Problems
☐ Neck Pain	☐ Digestive Disorders	☐ Frequent Colds	☐ ADD / ADHD
☐ Low Back Pain	☐ Stomach Aches	☐ Sinus Troubles	☐ Bedwetting
☐ Leg/Foot Pain	☐ Constipation/Diarrhea	☐ Heart Problems	☐ Other ________________

- Anything else we need to know about your health? ____

CHIROPRACTIC HISTORY

Have you ever been to a chiropractor before? Yes☐ No☐ Date of last chiropractic visit: _____________

Are other family members under chiropractic care? Yes☐ No☐ Who? ____________________________

The vast majority of our patients have experienced dozens of falls or impacts (sports/hobby/work related) that could cause Vertebral Subluxations. Help us discover a few of yours.

- Which of the following sports have you been involved in? Football☐ Basketball☐ Soccer☐ Running☐ Gymnastics/Cheerleading☐ Martial Arts☐ Other☐ ____
- Have you ever ….Fallen down the stairs☐ Slipped/Fell on the ground (or ice) ☐ Had a sports injury☐ Broken a bone☐ If so, which one: _________________________
- Have you been involved in any car accidents/fender benders? Yes☐ No☐ Date _________________

Name of Family Doctor/Pediatrician : ____

Have you ever been seen on an emergency basis? Yes☐ No☐ Reason/Date: ________________________

Exercise: None☐ 1-3x week☐ 4-7x week☐ Only PE☐ Sports☐ Other:_______________________

Please list any past surgeries (or traumas) and dates: ____

How many hours of sleep do you get? _________ Do you have trouble falling asleep? _________________

Do you sleep on your stomach? ___________

DIETARY / MEDICATION HISTORY

Please list number of doses of antibiotics you have taken:

During the past 6 months: _____________ During your lifetime: _________________________

Please list name and number of doses of any medications (prescription or OTC) taken:

During the past 6 months:_______________ During your lifetime: __________________________

Please list all medications you take or have taken: ____

Please list any vitamins/supplements you are taking: ____

Vaccination history: ______________________________________ Any reaction to them?______________

Do you consume (check all that apply): Soda ______ White Flour products _______ Fast Foods ______

Fried Foods _____ Sweets ______ Dairy/Milk products ______ Meat/Fish _______

Do you have any food allergies (please list them): ____

WHEN YOUR MOM WAS PREGNANT WITH YOU, your PRENATAL HISTORY – please fill out:

Location of Birth: Home ____ Birthing Center ____ Hospital (CNM or OB?) __________________________

Please list any complications during pregnancy/delivery:____

Medications during pregnancy/delivery :__________________Number of ultrasounds during pregnancy: _____

Birth intervention: Forceps _____ Vacuum _____ Caesarian: planned or emergency: ___________________

How long were you breastfed? _________ Were all developmental milestones met on time? ______________

I hereby authorize Stone Family Chiropractic Center and its Doctors to administer such to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office. I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself, and that I am personally responsible for payment of any and all services non-covered. I also understand that if I suspend or terminate my child's care and treatment, any fees for professional services rendered will immediately be due and payable.

______________________________________ __________________

Parent/ Guardian Signature Date