CONCORD CHIROPRACTIC CLINIC

WELCOME TO OUR OFFICE

MINOR

MINOR PATIENT NAME: ____

BIRTH DATE: _______________ AGE: _____ CELL#: __________________

PARENT/GUARDIAN: ____

ADDRESS: ______________________________ CELL #: ___________________

CITY/STATE: ____ZIP: _________

E-MAIL: ______________________________ MARITAL STATUS: S M D W

INSURANCE: No_____Yes_____

INSURED NAME: __________________________ BIRTH DATE: __________

INSURANCE COMPANY: ____

EMPLOYER: ____

ADDRESS: ______________________________________ PHONE: _________

CITY/STATE: ____ ZIP: ________

SPOUSE: _______________________________ BIRTH DATE: _____________

EMPLOYER: ____

ADDRESS: ____________________________________ PHONE: ____________

CITY/STATE: ____________________________________ CELL#: __________

I hereby give my permission to the doctor and staff to administer and perform such general procedures and treatments as he may deem necessary in the diagnosis and/or treatment of my child's condition. I hereby give my permission to release any protected information requested by my insurance company. I authorize, assign, and direct my, or any other insurance, company benefits to be paid directly to the doctor. I understand that I am financially responsible for any and all non-covered services, deductibles, and co-payments. In the event that my account must be turned over to a collection agency because of non-payment, I agree to pay any and all collection expenses (35%) plus attorney's fees and court costs.

SIGNED BY PARENT/GUARDIAN: ____________________________ DATE: ___________

CHART#:______________________

CASE HISTORY

Patient's Name____________________________________**Date**____________

CURRENT CONDITION

Date of Onset____________________ **Sudden** _______ **Gradual** _________

Non-Traumatic_______ **Traumatic**_______ **Cause Unknown** _______

Chief Complaint(s) ____

____

____

____

Injury: Sports _____ **Auto Accident**_____ **Work-Related**_____ **Home** ____

Describe what happened. ____

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____

On a scale of 1 -10, with 10 being the worst, rate your pain. _________

What makes the pain worse?____

____

Is your pain: Constant ______ **Intermittent** ______ **Occasional** ______

Describe the pain: Check all that apply.

Mild ____ **Moderate**____ **Severe**____ **Stiff**____ **Tight**____ **Sore**____ **Dull**___

Swollen ____**Aching**____ **Nagging**___ **Burning**___ **Sharp**____ **Stabbing**____

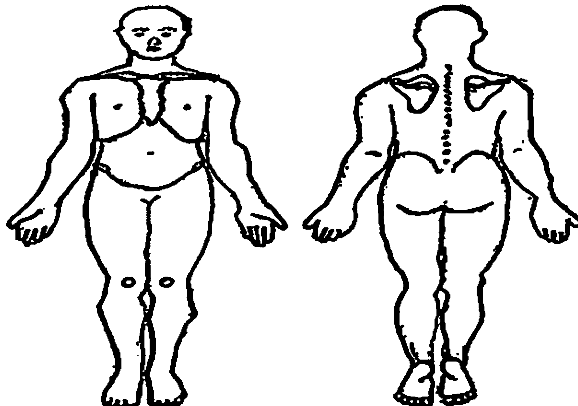
Shooting ____ **Nauseating** ____ **Radiating** _____ **Tingling** ____ **Numb**____

Pins and Needles _____

What relieves the pain?____

____

(Please mark areas of pain.)



Have been treated for the current complaints? Yes____ **No**____

Doctor's Name:__________________________________**Date:**___________

Treatment:____

Results:____

CASE HISTORY

MEDICAL HISTORY

Patient Name: ______________________________ **Date:**__________

Previous Chiropractic Care: Condition(s) & Dates Treated?

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____

Current Vitamins/Supplements: ______________________________

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____

Medical Diagnoses – Acute or Chronic (conditions & dates)

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Previous Tests and Dates Performed: (Mark N/A if not applicable.)

X-rays (regions & dates) ______________________________

____

MRI (regions & dates) ______________________________

____

Blood work (type & date) ______________________________

____

Other Tests (types & dates) ______________________________

____

Significant Health Problems

Hospitalizations or ER Visits & Dates ______________________________

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____

Surgeries & Dates______________________________

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Broken Bones/Dislocations & Dates ______________________________

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