



SOUTHERN ILLINOIS
CHIROPRACTIC CENTER

WELCOME

HELP YOUR BODY HEAL ITSELF WITH CHIROPRACTIC

Thank you for choosing our practice for your chiropractic needs!

PLEASE PRINT

Today's Date: _____

Patient Information:

Name: _____ **Nickname:** _____ **Age:** _____
Child/Teen Home Address: _____
Child/Teen Home Phone Number: _____ **Sex:** M F **Birthdate:** _____
SS#: _____

Family Information:

Mother's Name: _____ **Father's Name:** _____
Home Phone: _____ **Home Phone:** _____
Work Phone: _____ **Work Phone:** _____
Parent's Marital Status: Married Single Divorced Widowed

List names and ages of other children in household:

Payment Information & Consent to Treat:

Is your child/teen covered under a private or state funded health insurance? Yes No

If you do have health insurance for your child, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for the child's health insurance coverage.

Policyholder's name: _____ **ID#:** _____
Name of Insurance Company: _____ **Group #:** _____

Being the parent or legal guardian of this child/teen, I hereby authorize this office and its doctors to examine and administer care to my son/daughter named _____ as the examining/treating doctor deems necessary. I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Printed Parent's Name: _____

Signed Parent's Name: _____

Date: _____

Employee Signature: _____

Date: _____

Patient's Current Condition:

Reason for today's visit: _____ My child/teen has specific symptoms _____ Wellness Visit

What are the specific symptoms for **today's visit**? Please circle all that apply.

Allergies	Colic	Neck Pain
Asthma	Ear Infection	Shoulder Pain
Back Pain	Headaches	Sports Injury
Bed Wetting	Knee Pain	Other: _____

When did the symptom(s) first appear? _____

Have they had similar symptoms in the past? Yes No

What other treatment have you sought for these symptoms? _____

Has your child/teen ever been treated by a chiropractor? Yes No

If yes, where and when was their last adjustment? _____

Patient's Health History:

Has your child/teen had any recent falls or traumas? Yes No

If yes, please describe: _____

Has your child/teen ever fallen down stairs or from any height? Yes No

Has your child/teen ever been in a motor vehicle accident? Yes No

Has your child/teen ever had a bone fracture or joint dislocation? Yes No

Has your child/teen ever had colic? Yes No

Has your child/teen ever had upper respiratory infections? Yes No

Does your child/teen ever complain of headaches? Yes No

Does your child/teen ever complain of arm or leg pain? Yes No

Has your child/teen ever had an ear infection? Yes No

Has your child/teen ever had any other significant illnesses? Yes No

If yes, please explain: _____

Is your child/teen receiving any prescription or over-the-counter medications? Yes No

If yes, please list them: _____

Has your child/teen ever been vaccinated? Yes No

Does your child/teen live in a smoke free environment? Yes No

Has your child/teen ever had any surgeries? Yes No

If yes, please explain: _____

Please list any other concerns you have regarding your child's/teen's health:
