Voithofer Chiropractic
& Accident Rehabilitation

PEDIATRIC PATIENT

DATE

CHILD'S NAME GENDER ☐ MALE ☐ FEMALE

DATE OF BIRTH AGE SOCIAL SEC. #

BIRTH HEIGHT BIRTH WEIGHT CURRENT HEIGHT CURRENT WEIGHT

STREET ADDRESS CITY ST ZIP

PEDIATRICIAN/FAMILY MD CITY, ST LAST VISIT

MOTHER'S NAME D O B S S #

STREET ADDRESS CITY / ST / ZIP

PHONE NUMBERS: HOME CELL

EMAIL ADDRESS

FATHER'S NAME D O B S S #

STREET ADDRESS CITY / ST / ZIP

PHONE NUMBERS: HOME CELL

EMAIL ADDRESS

WHO IS RESPONSIBLE FOR THE BILL?

☐ FATHER D.L. # _____ ☐ MOTHER D.L. #_____

☐ OTHER _____

*(Please explain)*_____

_____

EMERGENCY CONTACT

NAME _____ PHONE_____ RELATIONSHIP _____

NAME _____ PHONE_____ RELATIONSHIP _____

PURPOSE OF VISIT

☐ WELLNESS CHECK-UP ☐ INJURY / ACCIDENT ☐ OTHER: _____

HAS YOUR CHILD EVER BEEN TREATED BY ANOTHER CHIROPRACTOR? ☐ YES ☐ NO

IF YES, WAS IT A POSITIVE EXPERIENCE? ☐ YES ☐ NO IF "NO" PLEASE EXPLAIN: _____

_____

PATIENT NAME_____ DATE _____

PLEASE DESCRIBE ANY PAIN / DISCOMFORT YOUR CHILD IS EXPERIENCING:

_____

LOCATION OF PAIN / DISCOMFORT: _____

WHEN DID THIS BEGIN?_____

HAS THIS HAPPENED BEFORE? ☐ YES ☐ NO IF YES, WHEN? _____

ANY BOWEL OR BLADDER PROBLEMS SINCE THE PROBLEM BEGAN? ☐ YES ☐ NO

IF SO, EXPLAIN: _____

HAVE YOU SEEN A DOCTOR FOR THIS PROBLEM? ☐ YES ☐ NO

DOCTOR'S NAME_____

RESULT OF PAST TREATMENTS: _____

_____

HOW IS THIS PROBLEM **NOW**?

☐ RAPIDLY IMPROVING ☐ IMPROVING SLOWLY ☐ ABOUT THE SAME ☐ GRADUALLY WORSENING ☐ ON & OFF

WHAT MEDICATION, IF ANY, IS BEING TAKEN FOR THIS PROBLEM?_____

PLEASE DESCRIBE ANY INJURIES YOUR CHILD HAS SUSTAINED.

☐ AUTO ACCIDENT: _____

☐ SPORTS: _____

☐ OTHER:_____

HAS YOUR CHILD EVER SUFFERED FROM:

☐ HEADACHES	☐ ORTHOPEDIC PROBLEMS	☐ DIGESTIVE DISORDERS	☐ ADD / ADHD	☐ DIZZINESS
☐ NECK PROBLEMS	☐ BEHAVIORAL PROBLEMS	☐ POOR APPETITE	☐ ARM PROBLEMS	☐ FAINTING
☐ STOMACH ACHES	☐ SEIZURES / CONVULSIONS	☐ RUPTURES / HERNIA	☐ LEG PROBLEMS	☐ REFLUX
☐ MUSCLE PAIN	☐ HEART TROUBLE	☐ JOINT PROBLEMS	☐ CONSTIPATION	☐ BACKACHES
☐ GROWING PAINS	☐ VISION / HEARING LOSS	☐ CHRONIC EARACHES	☐ DIARRHEA	☐ ASTHMA
☐ POOR POSTURE	☐ HYPERTENSION	☐ SINUS TROUBLE	☐ SCOLIOSIS	☐ ANEMIA
☐ COLDS / FLU	☐ WALKING TROUBLE	☐ SLEEPING PROBLEMS	☐ BROKEN BONES	☐ COLIC
☐ BED WETTING	☐ FALL FROM MONKEY BARS	☐ FALL IN BABY WALKER	☐ FALL OFF HIGH CHAIR	☐ FALL OFF BIKE
☐ FALL FROM CRIB	☐ FALL FROM CHANGING TABLE	☐ FALL FROM BED / COUCH	☐ FALL DOWN STAIRS	☐ FALL OFF SWING

☐ ALLERGIES_____

☐ OTHER_____

I understand that I am directly and fully responsible to Voithofer Chiropractic & Accident Rehabilitation for all fees associated with the chiropractic care my child receives. It has been explained to me that all fees paid for x-rays taken at this office are for the examination, and that I am entitled only to a copy of the written imaging report, which explains the result of my child's examination. The actual films are considered part of my child's original health record, and as such will not be released to anyone, under any circumstances, including me. I further understand and agree that they are the sole legal property of this practice, and that by law, the doctor must retain these films for a period of no less than seven years.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor.

After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child, for whom and on behalf of I have the legal right to select and authorize health care services.

PARENT / AUTHORIZED PERSON_____ DATE _____