

APPLICATION FOR CARE AT CORRECTIVE CARE CHIROPRACTIC **Child** (CCC)

PATIENT INFORMATION

Name: _____ Birth Date: ____/____/____ Age: _____ Male Female

Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Father: _____ Mother: _____

Home Phone: _____ Mobile Phone: _____/_____

Who referred you to our clinic? : _____

HISTORY OF COMPLAINT

Please identify if you came to this office, not as a result of a complaint, but for wellness care by completing the following:

Your Goals of Wellness Care:

Please identify, if any complaints, injury or illnesses that brought you to this office:

When did these problem(s) begin? _____ is your child's problem(s) the result of ANY type of accident. Yes No

If yes identify type: Auto Home Other (*please*

explain): _____ Date of Accident: _____

Has your child suffered with any of this or a similar problem(s) in the past? No Yes

If yes, when _____

Please state what type of treatment your child has tried for this problem(s):

Who provided it: _____ **When?** _____

What were the results? Favorable Unfavorable → please explain:

Is your child currently taking any medications? PLEASE LIST:

***PLEASE MARK** the areas on the Diagram with the following letters to describe your child's symptoms: **R=Radiating B=Burning D=Dull A=Aching**
S=Sharp/Stabbing T=Tingling N=Numbness

What percentage of the day does your child experience symptoms: _____%

What relieves the symptom(s)?

What makes them feel worse?

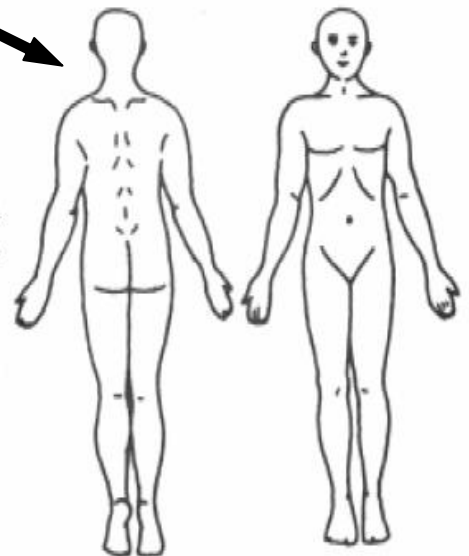
Has your child had previous chiropractic care? Yes No

Name of previous Chiropractor:

What were the results?

On a scale of 1 to 10 with 10 being the worst pain and 0 being no pain,

Rate how you feel **today (Circle the number)**: 1-2-3-4-5-6-7-8-9-10



PAST HISTORY

If your child has ever been diagnosed with any of the following conditions please indicate with a

P for in the **Past**, **C** for **Currently** have and **N** for **Never** have had a:

- Disability Broken Bone Fracture Dislocations Tumors Diabetes
- Heart Attack Rheumatoid Arthritis Osteo Arthritis Cerebral Vascular
- Other serious conditions: _____

PLEASE, identify ALL PAST and any CURRENT conditions you feel may be contributing to your child’s present problem:

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? **No** **Yes, if yes whom:**
 grandmother grandfather mother father sister(s) brother(s) son(s) daughter(s)
 Have they ever been treated for their condition? No Yes I don’t know
2. Any other hereditary conditions the doctor should be aware of. No Yes: _____

I hereby authorize payment to be made directly to Corrective Care Chiropractic for all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Corrective Care Chiropractic.

I request the clinic to submit claims to this insurance company: _____.

Please provide your insurance card to us for copying. We will determine eligibility.

Patient or Authorized Person’s Signature

Date

CONSENT TO TREAT A MINOR

MINOR PATIENT’S NAME: _____

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

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse /former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way I will immediately notify this office.

Parent /Legal Guardian

Date