stamford | balance
chiropractic studio

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Today's Date: _____ /_____ / _____

CONFIDENTIAL HEALTH INFORMATION

Personal Information

Child's Full Name: ____ ☐ Male ☐ Female

Prefers to be called: _______________________ Birth Date: _____ /_____ / _____ Age: __________

Parent or guardian's name if patient is a minor: ____

Home Address: ____

City: ____________________________________ State: ________ Zip Code: _______________

Home Phone: (______) ______________________ Parent Cell: (______) ______________________

Parent Email Address: ____

Today's Visit:

Reason(s) for seeking care: ____

____

____

Have you seen any other healthcare providers for this condition? ☐ Yes ☐ No

If yes, who? ____

General Health:

Please check any current or past issues your child has had from this list below:

☐ ADHD	☐ Constipation	☐ Hernias	☐ Paralysis
☐ Allergies	☐ Convulsions	☐ Hyperactivity	☐ Poor Appetite
☐ Anemia	☐ Cough/Wheeze	☐ Hypertension	☐ Poor Memory
☐ Arm/Elbow Pain	☐ Diabetes	☐ Insomnia	☐ Rashes/Hives
☐ Arthritis	☐ Diarrhea	☐ Itchy Eyes	☐ Rheumatic Fever
☐ Asthma	☐ Digestive	☐ Joint Pain	☐ Runny Nose
☐ Autism	☐ Dizziness	☐ Knee/Foot Pain	☐ Scoliosis
☐ Backaches	☐ Fainting	☐ Leg/Hip Pain	☐ Sinus Trouble
☐ Bed Wetting	☐ Fever/Chills	☐ Muscle Pain	☐ Sprains/Strains
☐ Behavior Problems	☐ Frequent Colds	☐ Neck pain	☐ Stomach Aches
☐ Blood Disorders	☐ Growing Pains	☐ Neuritis	☐ Tuberculosis
☐ Chest Pain	☐ Headaches	☐ Nightmares	☐ Other: ____________
☐ Chronic Ear Infections	☐ Heart Condition	☐ Pain Urinating	____________________

Previous Chiropractor(s): ________________________ Reason for Care:__________________________

Name of Pediatrician: ___________________________ Date of last visit: __________________________

Reason for visit: ____

Number of antibiotics taken in lifetime:______ Condition(s) treated: ______________________________

Please list any medications (Both prescription and over the counter): _______________________________

____

Has your child been injured in any type of accident (ie. Sports, car accident, major fall, etc.)? ☐ Yes ☐No

If yes, please describe with dates: ____

____

Has your child had any surgeries? ☐ Yes ☐No

If yes, please describe with dates: ____

Developmental History

Number of hours sleeping per night: __________ Quality of sleep: ☐ Good ☐ Fair ☐ Poor

At what age was your child able to:

Respond to sound ________ Follow object with eyes ________ Hold head up ________

Crawl ________ Sit alone ________ Stand alone _________ Walk alone _______ Say words _______

Section 6: Health Goals

People seek chiropractic care for a variety of reasons. Some people seek symptom relief, others want to correct the cause of the symptoms, and some are seeking to better their health in general. In our office, you and the doctor will discuss your child's health and current health issues, and choose a plan that is best for your child's needs. As of right now, let us know what type of care you care you are seeking:

☐ Relief Care: Symptomatic relief of pain or discomfort (a temporary fix to an underlying problem)
☐ Corrective Care: Correcting and relieving the cause of the problem, as well as the symptoms arising from it
☐ Comprehensive Wellness Care: Achieving a high state of health and function within the body
☐ Not sure yet

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctor(s) to administer care 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.

Parent or Guardian-Print: ____________________________ Relationship to minor: ________________________

Signature: ____ Date: _____ /_____ / _____