GARDEN STATE FAMILY CHIROPRACTIC **Ages 10-17**

Thank you for choosing our office to take care of your health needs.
To help us serve you better, please complete the following information.

Today's Date: _____

PATIENT INFORMATION

Print Full Name: _____ Name you go by: _____
Parent's/Guardian's Names: _____
Street Address: _____City: _____ State: _____ Zip: _____
Age: ____ Height: _____ Weight: _____ Date of Birth: _____ Sex: Male☐ Female☐
Number of siblings _____ Patient's email address (if applicable) _____
Where did you hear about our office or who referred you? _____
Phone Numbers:
Home: _____ Parents Work: _____ ext.____ Parent Cell: _____
Parent/Guardian E-mail address: _____

INSURANCE

Do you have medical insurance? Yes☐ No☐ Insurance Company Name: _____
Policy Number: _____ Insurance Company Phone Number: _____
Insured's Name (if different from patient): _____ Relationship to patient: _____
Insured's Date of Birth: _____ Insured's Social Security Number: _____

HEALTH HISTORY

If you have no symptoms or complaints and are here for wellness services, please check ☐; otherwise briefly describe the reason for seeking chiropractic care: _____

Is this due to an accident or injury? Yes☐ No☐ Date: _____Type of accident: Auto☐ Other: _____
Does it interfere with your (circle all that apply): Work/School Sleep Daily routine Exercise
Have you seen other doctors for this condition? Yes☐ No☐ Dr's name:_____
Please fill in the blanks below describing the chief complaint that you have:

- **How long** have you had the above complaints? _____
- **How often** do you have the above complaints? _____
- Is your pain **sharp, dull throbbing, burning, numb** and/or **achy?** _____
- Is your pain worse in the **morning, evening,** and/or **after a specific activity?** _____

- Have you ever experienced (check all that apply):

☐ Headaches/Migraines	☐ Colic/Reflux	☐ Ear Infections	☐ Growing Pains
☐ Dizziness	☐ Poor Appetite	☐ Asthma	☐ Female/Male Problems
☐ Fainting/Seizures	☐ Sugar Cravings	☐ Allergies	☐ Behavioral Problems
☐ Neck Pain	☐ Digestive Disorders	☐ Frequent Colds	☐ ADD / ADHD
☐ Low Back Pain	☐ Stomach Aches	☐ Sinus Troubles	☐ Bedwetting
☐ Leg/Foot Pain	☐ Constipation/Diarrhea	☐ Heart Problems	☐ Other _____

- Anything else we need to know about your health? _____

CHIROPRACTIC HISTORY

Have you ever been to a chiropractor before? Yes☐ No☐ Date of last chiropractic visit: _____
Are other family members under chiropractic care? Yes☐ No☐ Who? _____

The vast majority of our patients have experienced dozens of falls or impacts (sports/hobby/work related) that could cause Vertebral Subluxations. Help us discover a few of yours.

- Which of the following sports have you been involved in? Football☐ Basketball☐ Soccer☐ Running☐ Gymnastics/Cheerleading☐ Martial Arts☐ Other☐ _____
- Have you ever ….Fallen down the stairs☐ Slipped/Fell on the ground (or ice) ☐ Had a sports injury☐ Broken a bone☐ If so, which one: _____
- Have you been involved in any car accidents/fender benders? Yes☐ No☐ Date _____

Name of Family Doctor/Pediatrician : _____
Have you ever been seen on an emergency basis? Yes☐ No☐ Reason/Date: _____
Exercise: None☐ 1-3x week☐ 4-7x week☐ Only PE☐ Sports☐ Other:_____
Please list any past surgeries (or traumas) and dates: _____
How many hours of sleep do you get? _____ Do you have trouble falling asleep? _____
Do you sleep on your stomach? _____

DIETARY / MEDICATION HISTORY

Please list number of doses of antibiotics you have taken:
During the past 6 months: _____ During your lifetime: _____
Please list name and number of doses of any medications (prescription or OTC) taken:
During the past 6 months:_____ During your lifetime: _____
Please list all medications you take or have taken: _____
Please list any vitamins/supplements you are taking: _____
Vaccination history: _____ Any reaction to them?_____
Do you consume (check all that apply): Soda _____ White Flour products _____ Fast Foods _____
Fried Foods _____ Sweets _____ Dairy/Milk products _____ Meat/Fish _____
Do you have any food allergies (please list them): _____

WHEN YOUR MOM WAS PREGNANT WITH YOU, your PRENATAL HISTORY – please fill out:

Location of Birth: Home ____ Birthing Center ____ Hospital (CNM or OB?) _____
Please list any complications during pregnancy/delivery:_____
Medications during pregnancy/delivery :_____Number of ultrasounds during pregnancy: _____
Birth intervention: Forceps _____ Vacuum _____ Caesarian: planned or emergency: _____
How long were you breastfed? _____ Were all developmental milestones met on time? _____

I hereby authorize Garden State Family Chiropractic and its Doctors to administer such 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. I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself, and that I am personally responsible for payment of any and all services non-covered. I also understand that if I suspend or terminate my child's care and treatment, any fees for professional services rendered will immediately be due and payable.

_____ _____
Parent/ Guardian Signature Date