



# Pediatric Patient Introduction

## Ages 5-17

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Address: \_\_\_\_\_ Male / Female  
 \_\_\_\_\_  
 Mother' Name: \_\_\_\_\_ Best Number in which to contact you: \_\_\_\_\_  
 Father's Name: \_\_\_\_\_ Best Number in which to contact you: \_\_\_\_\_  
 Home: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Emergency Contact (different from parent) \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Siblings Names & Ages \_\_\_\_\_  
 \_\_\_\_\_

### Consent to Initiate Care

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. Our only practice objective is to eliminate subluxation which interferes with the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_, have read and fully understand the above statements.  
(Please Print Name of Parent/Guardian)

I hereby authorize the Doctor to provide any and all forms of evaluation, x-rays and care that may be indicated in connection with the patient \_\_\_\_\_, and further authorize the consent that the Doctor chooses and employs such assistance as he sees fit. I also understand that prior to care, a full explanation of the procedure(s) involved will be given. I agree to pay for all services rendered in this office.

Parent/Guardian Name

Parent/Guardian Signature

Date

# I. General Information

How did you hear of our office?

Business Card    Web Search    Doctor    Friend    Fitness Center    Event

Who may we thank for referring you? \_\_\_\_\_

Have you ever been to a Chiropractor before?

Yes    No

Date of Last visit: \_\_\_\_\_

Reason for Care: \_\_\_\_\_

How long were you under care: \_\_\_\_\_

Were x-rays taken?    Yes    No

# II. Chief Complaint

Reason for seeking Chiropractic Care today: \_\_\_\_\_

Is issue a result of:    Car Accident

School/Work Related

Other \_\_\_\_\_

Have you seen any other doctor for this problem?

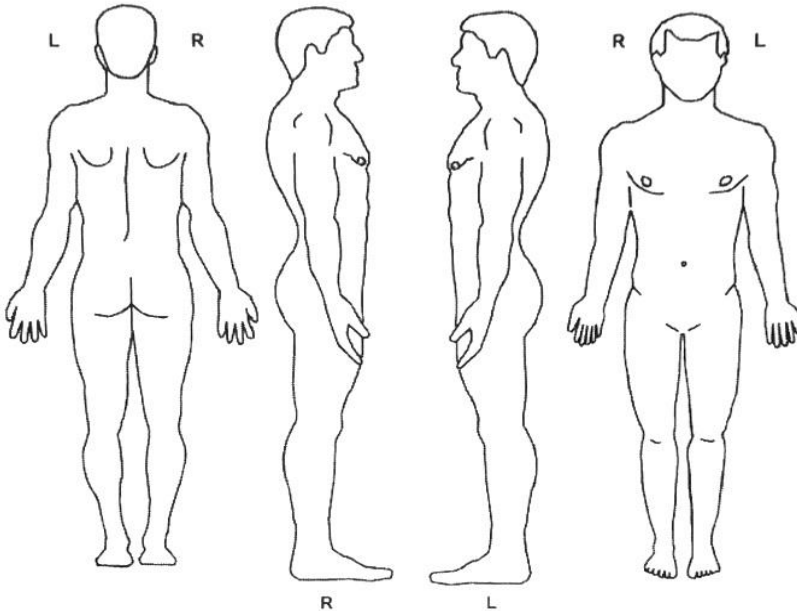
Yes    No

Dr. Name \_\_\_\_\_

List any medications: \_\_\_\_\_  
\_\_\_\_\_

Are you    Left Handed /    Right Handed

**Circle the areas where you have any problems**  
**Please also describe these problems.**



Mark as follows:  
A - Ache    B - Burning    N - Numbness    P - Pins & Needles  
S - Stabbing    O - Other - Describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

Doctor' Notes:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Have you had or have the following?

Symptoms or Problems	Constant or Frequent	Occasional
Pain:	_____	_____
Neck	_____	_____
Shoulder(s): Right Left Both	_____	_____
Arm/Hand: Right Left Both	_____	_____
Mid Back	_____	_____
Low Back	_____	_____
Hip/Sciatic: Right Left Both	_____	_____
Leg/foot: Right Left Both	_____	_____
Joints	_____	_____
Headaches or Migraines	_____	_____
Chest Pain	_____	_____
Joint Swelling	_____	_____
Muscle Spasms	_____	_____
Numbness/Tingling	_____	_____
Dizziness/Vertigo	_____	_____
Ringling in Ears	_____	_____
Cough	_____	_____
Flu/Fever	_____	_____
Weakness	_____	_____
Fatigue	_____	_____
Constipation	_____	_____
Diarrhea	_____	_____

Conditions	Constant or Frequent	Occasional
Insomnia	_____	_____
Anxiety	_____	_____
Depression	_____	_____
Blood Disorders	_____	_____
Kidney Problems	_____	_____
Epilepsy	_____	_____
Hearing Loss	_____	_____
Frequent Colds	_____	_____
Asthma	_____	_____
Allergies	_____	_____
Skin Conditions	_____	_____

## III. Childhood History (Prior to age 18)

Research is showing that many of the health challenges that occur later in life have their origins during our developmental years, some starting at birth. Please answer these questions to the best of your ability.

	Yes	No	Details
Did you have any childhood illnesses? (chicken pox, measles, etc.)	_____	_____	_____
Did you have any serious falls? (tree, seesaw, crib, etc.)	_____	_____	_____
Did/do you play sports?	_____	_____	_____
Did you have any surgeries?	_____	_____	_____
Prolonged use of medications? (antibiotics, inhalers, etc.)	_____	_____	_____
Any car accidents?	_____	_____	_____
Were you vaccinated?	_____	_____	_____
Were you under regular Chiropractic care?	_____	_____	_____
Do you :			
Carry a backpack in school?	_____	_____	Average weight of backpack _____
Carry backpack on one shoulder or both?	_____	_____	_____
Drink water?	_____	_____	_____
Consume Caffeine?	_____	_____	_____
Consume vitamins or supplements?	_____	_____	_____

On a scale of 1 (being none) to 10 (being severe), rate your stress at: Home \_\_\_\_\_ School \_\_\_\_\_

On a scale of Poor, Good, Excellent, describe your:

Diet \_\_\_\_\_ Exercise \_\_\_\_\_ Sleep \_\_\_\_\_ General Health \_\_\_\_\_

## V. Wellness Commitment

At Lighthouse Chiropractic, we are dedicated to achieving the goal of total lasting health for our members. To better help you achieve this we need to understand your commitment to being healthy. Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness:

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

## VI. Missed Appointment Policy

With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards are provided to help you save the date. If you need to re-schedule an appointment, please call our office and arrange for a make-up appointment. We would prefer the make up appointment to be within the same week.

In the instance of a no show, we reserve the right to charge you a \$20.00 fee. Thank you for your understanding.

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Parent/Guardian Name

Parent/Guardian Signature

Date

## Insurance Information (if applicable)

Name of insured \_\_\_\_\_

Date of Birth \_\_\_\_\_

Insurance Company \_\_\_\_\_

Phone # \_\_\_\_\_

ID # \_\_\_\_\_

Policy# \_\_\_\_\_

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Lighthouse Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid to Lighthouse Chiropractic will be credited to my account upon receipt. **However, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.** I also understand that if I suspend or terminate my case and treatment, any fees for professional services rendered me will be immediately due and payable.

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Patient Name

Patient Signature

Date

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Parent/Guardian Name

Parent/Guardian Signature

Date