

WELCOME TO MARION FAMILY CHIROPRACTIC

Information for Minors

Today's Date _____

Child's Name _____ Date of Birth _____ Age _____
Child's Nickname _____ Grade in School _____ Social Security # _____
Child's Address _____ Town _____
State _____ Zip _____ Phone Number _____

Father's Name _____ Date of Birth _____
Address (if different than child's) _____ Town _____
State _____ Zip _____ Phone Number _____
Occupation _____ Employer _____
Mother's Name _____ Date of Birth _____
Address (if different than child's/father's) _____ Town _____
State _____ Zip _____ Phone Number _____
Occupation _____ Employer _____
Names/Ages of Siblings _____
Person accompanying child today _____ Relationship _____

Authorization for care of minor (necessary if under age 18):

I hereby authorize Marion chiropractic to administer care as deemed necessary to my son/daughter/ward:

Signed _____ Date _____ Relationship _____

Person responsible for account _____

How did you learn about this office?

Personal referral Advertisement Sign Health Fair/Talk Other _____

If you were referred, please note their name so we may personally thank them _____

Reason for consulting this office:

- Wellness and preventive care
 Specific pain and/or health problems (please explain)

Has this child been under previous chiropractic care? (yes)(no)

If "yes," when was his/her last visit? _____

Is there anything else significant happening in this child's life that we should be aware of?

Demographic Data : Our Federal Office of Management and Budget (OMB) has asked that we collect the following Data. No personal information is associated with this data when we send it to OMB.

Race: American Indian or Alaskan Asian Black Caucasian Declined Other Race Pacific Islander

Ethnicity: Hispanic Non-Hispanic Declined

Language: Arabic Cantonese English French German Hindi Italian Japanese Korean Mandarin Other Persian Polish Portuguese Romanian Russian Spanish Tagalog Ukrainian Urdu Vietnamese

Please provide the following information:

Problems during pregnancy _____

Problems during labor/delivery _____

Type of birth: Normal vaginal _____ Home _____
Forceps _____ Breech _____ Birthing Center _____
Cesarean _____ Vacuum _____ Hospital _____

Birth Length _____ Apgar Scores _____ Congenital Anomalies/defects _____

Was there presence at birth of jaundice (yellow)? _____ Cyanosis (blue)? _____

How long was the infant breast fed? _____ Formula fed? _____ When did the child start eating solid foods? _____

Number of hours of sleep per night _____ Quality of sleep: Good ___ Fair ___ Poor ___

Has your child had any reactions to immunizations? _____ If so, please describe _____

Did your child's behavior change following any immunizations? _____ If so, how? _____

At what age did the child: Hold head up _____ Sit alone _____ Crawl _____ Walk alone _____

Has the child ever experienced:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Backaches | <input type="checkbox"/> "Growing Pains" | <input type="checkbox"/> Chronic Ear Aches |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Headaches | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Chronic Infections |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> 1-1 Diarrhea | <input type="checkbox"/> Colds/Flu |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Stomach Discomfort | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Muscle Jerking | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Ruptures/Hernias | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Obesity | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Dislocations | <input type="checkbox"/> Small for Age | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Other |

Medication History _____

Current Medications _____

Surgeries/Hospitalizations _____

Falls/Accidents/Other Injuries _____

How would you describe your child's diet? _____

Current medical doctor _____ Other health care providers _____

Our mission is to improve the quality of your child's life through natural healing, to decrease or eliminate the need for drugs and medications, and to allow your child to better express health and innate healing ability.

Welcome to our office.

Thank you. We look forward to providing your child's chiropractic care.

Dr Jennifer F. Eames
Dr Stacy R. Tam
Dr. James M. Gomes