



**Practice Member Application**  
Date: \_\_\_\_\_

Child's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F  
 Parent/ Guardian Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Employer's Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Date of Onset/ Injury: \_\_\_\_\_ Referred By: \_\_\_\_\_  
 Is injury a result of an accident: Yes/ No If Yes: Work/ Auto/ Other \_\_\_\_\_  
 Had chiropractic care previously? Yes/ No When: \_\_\_\_\_  
 Other health care providers your child sees: \_\_\_\_\_

Primary Insurance		Secondary Insurance	
Name of Insured:	Relationship to Pt:	Name of Insured:	Relationship to Pt:
DOB/ SS #	Employer:	DOB/ SS #	Employer:
Address (If different from above):		Address (If different from above):	
Insurance Company:		Insurance Company:	
ID Number:	Group:	ID Number:	Group:
Phone #		Phone #	

**Emergency Contact:**

Name:	Phone:	Relationship:
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Although service may be covered by insurance, I understand I am fully responsible for payment for care I receive. I authorize payment of medical benefits to my doctor for services rendered. I authorize the doctor or insurance to release any information required for services rendered by this office.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

The following is used to gather information regarding your child's current and past health status. Complete responses will provide your doctor with a better understanding of your health and allow better care to be provided.

What is the nature of your visit today? \_\_\_\_\_

When did it begin? \_\_\_\_\_ Is the problem constant or intermittent? (circle one)

What makes the problem better? \_\_\_\_\_ worse? \_\_\_\_\_



**0  
NO  
HURT**



**1  
HURTS  
LITTLE  
BIT**



**2  
HURTS  
LITTLE  
MORE**



**3  
HURTS  
EVEN  
MORE**



**4  
HURTS  
WHOLE  
LOT**



**5  
HURTS  
WORST**

Please check each as it applies. Has child ever had:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Allergies          | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Polio               |
| <input type="checkbox"/> ADD/ADHD           | <input type="checkbox"/> Ears Infection         | <input type="checkbox"/> Poor Posture        |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Eye Problems           | <input type="checkbox"/> Flu Shot            |
| <input type="checkbox"/> Back Pain          | <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Sensory Processing  |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Frequent Urination     | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Bedwetting         | <input type="checkbox"/> Headache               | <input type="checkbox"/> Sinus Infection     |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Head Banging           | <input type="checkbox"/> Sleep Trouble       |
| <input type="checkbox"/> Colic              | <input type="checkbox"/> Irregular Heart Beat   | <input type="checkbox"/> Scoliosis           |
| <input type="checkbox"/> Cold Extremities   | <input type="checkbox"/> Kidney Infection       | <input type="checkbox"/> Vaccinations        |
| <input type="checkbox"/> Constipation       | <input type="checkbox"/> Loss of Memory         | <input type="checkbox"/> Torticollis         |
| <input type="checkbox"/> Depression         | <input type="checkbox"/> Loss of Balance        | <input type="checkbox"/> Thyroid Condition   |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Neck Pain or Stiffness | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Nervousness            |  |

Please list any medications currently taking: \_\_\_\_\_

Has child ever been hospitalized? \_\_\_\_\_

Has child ever taken antibiotics? \_\_\_\_\_

Describe the child's birth:  Vaginal  Cesarean Section  Hospital  Home

Epidural  Other meds  Vacuum Extraction  Forceps

Was/is the child breast fed/ formula fed? (circle one)