GARNETT CHIROPRACTIC CENTER

_____ Date_____

Name_____

Address_____

_____Zip_____

SS#_____ Birthday_____ Age_____ Phone_____

Parent &/or Guardian_____

Referred By: _____ Do You Want Us To File Your Insurance? Yes or No

If Yes, Name & Address of Insurance Company: _____

_____

Please Check Any Symptoms Patient Has Experienced:

___Headaches ____Poor School Perf. ____Bedwetting ____Bladder Infections

___Stomach Pain ____Asthma ____Allergies ____Hyperactivity

___Colic ____Chronic Colds ____Leg Pain ____Unusually Clumsy

Other Health Concerns & Length of Time They've Been Noticed: _____

_____

_____

Has Child Had Any Surgeries? Yes or No If Yes, Type & Date: _____

_____

Medications: _____

What Was Child's Birth Like? _____

Length of Labor_____ Length of Pushing _____ Was Mother Induced? Yes or No

Nerve Block? Yes or No C-Section? Yes or No Any Pulling On Child's Head? Yes or No

Forceps or Vacuum Used? Yes or No Child's Most Recent Fall: _____

Was Any Care Given? Yes or No Was Child Checked By A Chiropractor? Yes or No

Other Accidents (Including Auto &/or Sports Related): _____

_____

_____ (over)

Spinal Subluxations Can Also Be Caused By Emotional Trauma.

Has Child Suffered Any Emotional Stress Lately? Yes or No Explain:_____

_____

I HEREBY AGREE THAT PAYMENT FOR CARE IS DUE THE SAME DAY AS OFFICE VISIT AND IT IS MY RESPONSIBILITY TO PAY FOR CARE, EVEN THOUGH I MAY OR MAY NOT BE REIMBURSED BY MY INSURANCE.

_____ _____

(signature of parent or guardian) (date)

Dr's Use Only:

Head Tilt: L R Derefield: L R

High Shoulder: L R Palpable Findings: _____

High Hip: L R _____

Thoracic Kyphosis: _____ Head Translation: Ant. L R

Other: _____

_____

X-Ray Listings: _____

_____

_____

DX: _____

Plan of Care: _____

_____

Prognosis: _____

_____