Dale Family Chiropractic, LLC

Patient Registration Form

Child's Name: _____ Sex: [ ] Male [ ] Female

Parent's/Guardian's Name:_____ Birthdate ____/_____/_____

Address: _____

City: _____

State: _____ ZIP: _____

Home: (_____)_____ May we leave a message? [ ] Yes [ ] No

Parent's Cell Phone: (_____)_____May we leave a message? [ ] Yes [ ] No

Parent's Work Phone: (_____)_____May we leave a message? [ ] Yes [ ] No

Parent's E-Mail: _____

Alternative Parent/Guardian's Name: _____

Name(s) and age(s) of children: of Children & ages:_____ _____ _____

Referred By: _____

Emergency Contact:

Name: _____ Relationship to Child: _____

Phone Number: _____ Alternative Phone Number: _____

Consent to Evaluation of a Minor Child

I _____being the parent or legal guardian

(print name of consenting adult)

of_____hereby grant permission for my child to receive a chiropractic

(print name of minor)

evaluation including history, spinal scan, examination and x-rays if warranted. Any findings will be communicated before consenting to commencement of care if appropriate.

_____ **DATE:**_____/_____/_____

Consenting Adult's Signature

Wellness Profile

What Signals has your child's body been communicating?

CURRENT	PREVIOUS		CURRENT	PREVIOUS		CURRENT	PREVIOUS	
☐	☐	Asthma	☐	☐	Frequent Diarrhea	☐	☐	Failure to Thrive / Slow Weight Gain
☐	☐	Respiratory Tract Infections	☐	☐	Constipation	☐	☐	Slow or Absent Reflexes
☐	☐	Sinus Problems	☐	☐	Flatulence	☐	☐	Asymmetrical Crawling or Gait
☐	☐	Ear Infections	☐	☐	Headaches/Migraines	☐	☐	Weight Challenges
☐	☐	Tonsillitis	☐	☐	Neck Pain	☐	☐	Bed Wetting
☐	☐	Strep Throat	☐	☐	Torticollis / Head Tilt	☐	☐	Sleep Problems
☐	☐	Frequent Colds / Croup	☐	☐	Trouble Feeding on One Side	☐	☐	Night Terrors
☐	☐	Recurrent Fevers	☐	☐	Back Pain	☐	☐	Tip Toe Walking
☐	☐	Eczema	☐	☐	Growing Pains	☐	☐	Regression of Milestones
☐	☐	Rashes	☐	☐	Scoliosis	☐	☐	Seizures
☐	☐	Allergies	☐	☐	Red, Swollen, Painful Joint	☐	☐	Tremors / Shaking
☐	☐	Food Sensitivites	☐	☐	Colic	☐	☐	ADD / ADHD
☐	☐	Digestive Problems	☐	☐	Frequent Crying Spells	☐	☐	Autism / PDD

Do you have a specific concern that brings you in?

[ ] No, I am interested in having my child's nervous system assessed to achieve optimal health and functioning.

[ ] Yes: _____

If yes, please answer the following questions,

Does your child appear to be in pain or discomfort? _____ How long has your child been experiencing this? _____

Is it getting better, worse or staying the same? _____ How long has your child been experiencing this? _____

Have you seen other health professionals regarding this complaint?

[ ] No [ ] if Yes, whom? _____

What treatment did they use? _____

Has your child taken any medication for this complaint.....[ ] No [ ] Yes _____

Has your child ever experienced this complaint before?.....[ ] No [ ] Yes_____

Did they receive any treatment at the time? .....[ ] No [ ] Yes_____

Has your child had x-rays in relation to the current complaint? [ ] No [ ] Yes_____

GUARDIAN SIGNATURE:_____ **DATE:**_____/_____/_____