

ABOUT THE PATIENT

153 Roberts Village Ct, Ste 1502, Fruit Cove, FL 32259

Name _____ Today's Date _____ Birthdate _____ Age _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____ Gender ☐ M ☐ F
 Significant Other's Name _____ Kid's Names and Ages _____
 Your Employer _____ Type of Work _____
 e-Mail Address _____ Have you been to a chiropractor before? ☐ No ☐ Yes
 Emergency Contact _____ ph # _____
 Name of Medical Doctor(s) _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Impact Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ☐ Cash ☐ Check ☐ Credit Card ☐ Car/Work Ins.

Patient / Parent Signature _____

(This represents a long term authorization for all occasions of service)

Date _____

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
2. _____ How long has this been an issue? _____
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
3. _____ How long has this been an issue? _____
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
4. _____ How long has this been an issue? _____
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
5. Does your condition affect: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ Driving
6. What makes it better? _____
7. What makes it worse? _____
8. What Doctor's have you seen for this? _____

9. Type of treatment: _____

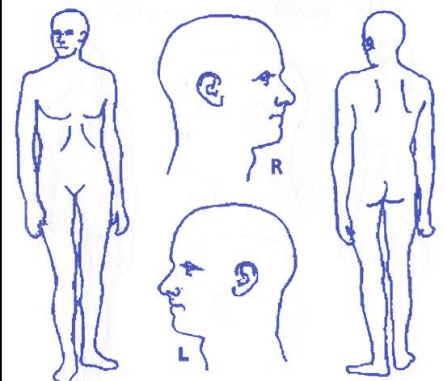
10. Results: _____

NOTES: _____

Are you pregnant?

☐ Yes ☐ No

Please mark all areas of concern.



GENERAL PED HEALTH HISTORY

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Patient Name _____ *Mark the conditions that apply to you.*

Past Present

- ☐ ☐ Headaches
- ☐ ☐ Ear Infections
- ☐ ☐ Colic
- ☐ ☐ Allergies / Asthma
- ☐ ☐ Medication Side Effects
- ☐ ☐ Recurring Fevers
- ☐ ☐ Digestive problems
- ☐ ☐ Bed Wetting
- ☐ ☐ Chronic Colds/Sinus
- ☐ ☐ Other _____

Past Present

- ☐ ☐ Vision Problems
- ☐ ☐ Sleeping Problems
- ☐ ☐ Growing Pains
- ☐ ☐ Dental Problems
- ☐ ☐ Temper Tantrums
- ☐ ☐ ADHD
- ☐ ☐ Seizures
- ☐ ☐ Scoliosis
- ☐ ☐ Ever Needed Stitches

1. List any medications being taken: _____
2. Number of courses of Antibiotics child has taken in the last 6 mo. _____ Total during lifetime _____
3. Name of Pediatrician and Other Doctors: _____
4. Date of Last Visit ____/____/____ Reason: _____
5. Name of Obstetrician/Midwife: _____
6. Location of Birth: ☐ Hospital ☐ Birthing Center ☐ Home
7. Complications During Pregnancy: ☐ No ☐ Yes Explain: _____
8. Ultrasounds During Pregnancy: ☐ No ☐ Yes How Many: _____
9. Medication During Pregnancy / Delivery ☐ No ☐ Yes List: _____
10. Cigarette / Alcohol Use during Pregnancy: ☐ No ☐ Yes
11. Has any Doctor / Other Professional advised you to "Take the child to a Chiropractor ": ☐ No ☐ Yes, Name _____

PAST HISTORY

12. List any past auto collisions: _____ Was any care received? _____
13. List any past falls bumps bruises: _____ Was any care received? _____
14. List any past sport, recreational, or home injuries: _____
15. Please describe any past conditions and treatment received: _____
16. Please list any past hospitalizations and surgeries: _____

FAMILY HISTORY

- Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other _____
- Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other _____
- Is there any other family history you want us to know? _____