KING CHIROPRACTIC
Spine & Wellness Center

7801 East Bush Lake Road Suite #280
Bloomington, MN 55439

ABOUT THE PATIENT: **13-18 YEARS**

Minor's Name: _____ **Today's Date:** _____

Parent Name (1): _____ **Parent Name (2):** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Parent Cell Phone:** _____ **E-Mail Address:** _____

Birthdate: ___/___/___ **Age:** _____ **Current Height:** _____ **Current Weight:** _____ **Gender:** ❑ **M** ❑ **F** ❑ _____

Our aim is to create a safe environment for our members and their families, is there anything you'd like to specifically and explicitly let us know? _____

Homelife: ❑ **Traditional Family (1 home)** ❑ **Single Parent** ❑ **Extended Family** ❑ **Stepfamily (2+ home)**

Number of Siblings: _____ **Names and Ages:** _____

Who may we thank for referring you in? _____ **Has the child ever been to a chiropractor?** ❑ **No** ❑ **Yes**

Your Employer: _____ **Type of Work:** _____

Emergency Contact: _____ **Phone #:** _____

- I authorize the doctor(s) or staff to render care as deemed appropriate for me and / or my child.
- I authorize **King 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.

_____ _____

Parent / Guardian 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 been seen for this? (if so who and when): _____

_____

9. Type of treatment: _____

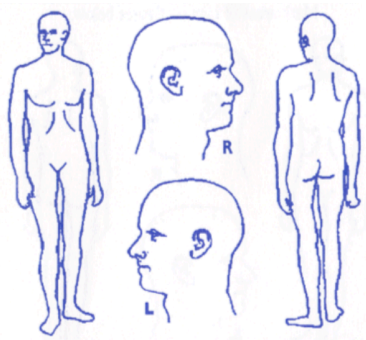
10. Results: _____

NOTES: _____

_____

_____

Are you pregnant?
❑ Yes ❑ No



Mark areas of complaint

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GENERAL HEALTH HISTORY

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

Past	Present		Past	Present	
❑	❑	Allergies / Asthma	❑	❑	Shortness of Breath
❑	❑	Depression	❑	❑	Blood Pressure ❑ High or ❑ Low
❑	❑	Chest Pains	❑	❑	High Cholesterol
❑	❑	Heart Pacemaker	❑	❑	Kidney Problems
❑	❑	Heart Disease	❑	❑	Liver Problems
❑	❑	Diabetes ❑ Type 1 or ❑ Type 2	❑	❑	Thyroid Problems
❑	❑	Stroke History	❑	❑	Urinary Problems
❑	❑	Ear Problems	❑	❑	HIV
❑	❑	Fainting	❑	❑	Muscle Aches
❑	❑	Light Bothers Eyes	❑	❑	Trouble Walking
❑	❑	Headaches / Migraines	❑	❑	Tension / Irritability
❑	❑	Seizures	❑	❑	Fibromyalgia
❑	❑	Nausea / Vomiting	❑	❑	Scoliosis
❑	❑	Ringing in Ears	❑	❑	Leg / Foot Numbness
❑	❑	Sleeping Problems	❑	❑	Infertility
❑	❑	Dental Problems / Surgeries	❑	❑	Menstrual Problems
❑	❑	TMJ - Jaw Pain / Clicking	❑	❑	Blood Thinner Use
❑	❑	Vision Problems	❑	❑	Easy Bruising
❑	❑	Gallbladder Problems	❑	❑	Hands or Feet Cold
❑	❑	Medication Side Effects	❑	❑	Digestive Problems
❑	❑	Alcohol Use - Amount/week: _____	❑	❑	Replacements ❑ Hip or ❑ Knee
❑	❑	Tobacco Use - Amount/week: _____	❑	❑	Other _____
❑	❑	Cancer - Type / Remission: _____			

1. **Known ALLERGIES or FOOD INTOLERANCE:** _____
2. **ANTIBIOTIC courses:** ❑ No ❑ Yes taken in the last 6 mo. ____ Total during lifetime ___ Reaction: _____
3. **BEHAVIORAL, SOCIAL, or EMOTIONAL issues?** ❑ No ❑ Yes Reaction: _____
4. **Diet:** ❑ Mostly whole, organic foods ❑ Pretty average ❑ High amount of processed foods
5. **List any MEDICATIONS being taken:** _____
6. **VACCINATIONS:** ❑ No ❑ Yes Reaction: _____
7. **Changes / stressor in HOME / SCHOOL:** _____
8. **Has any Doctor / Professional advised you to "Take your child to a Chiropractor?"** ❑ No ❑ Yes - Name: _____

PAST HISTORY

9. **List any past AUTO collisions / dates:** _____ **Was any care received?** _____
10. **List any past sport, recreational, or home injuries:** _____
11. **Ever been knocked unconscious?** ❑ No ❑ Yes **8. Fractured any bones?** ❑ No ❑ Yes
12. **Have you had any spinal x-rays / MRI's / CT's taken in the last year? If so, where?** _____
13. **Please list HOSPITALIZATIONS and SURGERIES (if any) and dates:** _____

14. **Any MAJOR INJURIES, ACCIDENTS, FALLS or FRACTURES and dates:** _____

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? _____

What are your expectations with care at King Chiropractic? _____