King Chiropractic
Spine & Wellness Center

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

ABOUT THE PATIENT: **4-12 YEARS**

Child'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

PLEASE DESCRIBE HEALTH CONCERN(S):

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

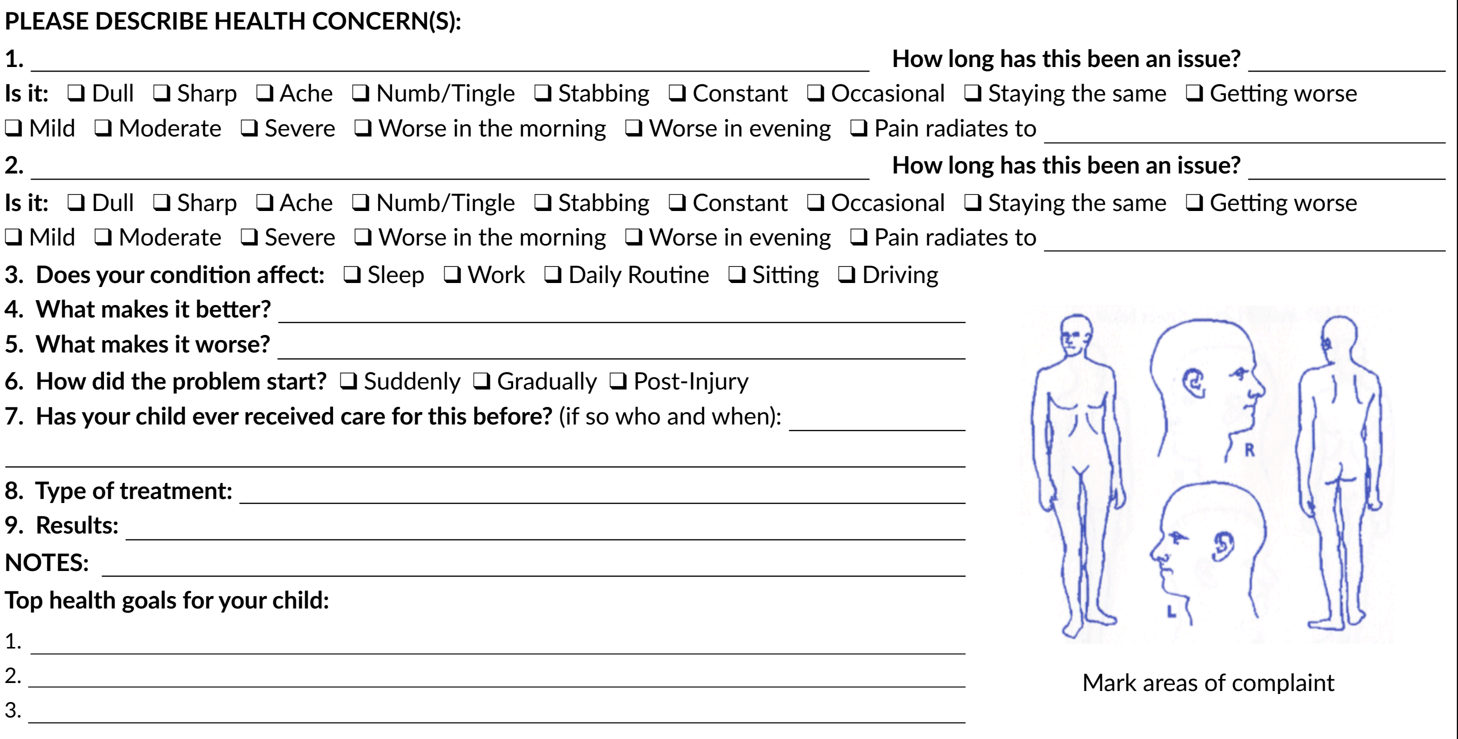
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to ________

3. **Does your condition affect:** ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving
4. **What makes it better?** ________________
5. **What makes it worse?** ________________
6. **How did the problem start?** ❑ Suddenly ❑ Gradually ❑ Post-Injury
7. **Has your child ever received care for this before?** (if so who and when): ________________
8. **Type of treatment:** ________________
9. **Results:** ________________

NOTES: ________________

Top health goals for your child:

1. ________________
2. ________________
3. ________________



Mark areas of complaint

PARENT'S 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 ________

CHILD'S GENERAL HEALTH HISTORY

Patient Name: ______________________________ ***Mark the conditions that apply.***

Past	Present	Condition	Past	Present	Condition
❏	❏	Headaches / Migraine	❏	❏	Vision Problems
❏	❏	Dizziness / Vertigo	❏	❏	Grating of Neck
❏	❏	Nervousness	❏	❏	Stomach Disorders
❏	❏	Ear Infections	❏	❏	Night Terrors / Sleeping Problems
❏	❏	Colic	❏	❏	Growing Pains
❏	❏	Bowel Problems	❏	❏	GERD
❏	❏	Trouble Eating	❏	❏	Rashes
❏	❏	Asthma	❏	❏	Dental Problems
❏	❏	Medication Side Effects	❏	❏	Temper Tantrums
❏	❏	Recurring Fevers	❏	❏	Sensory Processing Issues
❏	❏	Throat Issues	❏	❏	ADD / ADHD
❏	❏	Abnormal Fatigue / Depression	❏	❏	Abnormal Appetite
❏	❏	Digestive Problems	❏	❏	Seizures
❏	❏	Bed Wetting	❏	❏	Scoliosis
❏	❏	Difficult Breast Feeding	❏	❏	Nausea / Vomiting
❏	❏	Heart Disorders	❏	❏	Torticollis
❏	❏	Latching / Nursing Problems	❏	❏	Tongue / Lip Tie
❏	❏	Autism Spectrum Disorder	❏	❏	Bladder Problems
❏	❏	Chronic Colds / Sinus Problems	❏	❏	Epilepsy
❏	❏	Other ______________________________			

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; alternate ❏ Yes; schedule Reaction: ______________________________

7. Changes / stressor in HOME / SCHOOL: ______________________________

8. Has any Doctor / Professional advised you to "Take your child to a Chiropractor?" ❏ No ❏ Yes - Name: ______________

CHILD'S BIRTH / GROWTH AND DEVELOPMENT HISTORY

Name of child's current primary Doctor(s): ______________________________

Date of last visit _____/____/_____ **Reason:** ______________________________

Location: ❏ at home birth ❏ at a birthing center ❏ at a hospital ❏ other: ______________

Child's birth was: ❏ vaginal birth ❏ scheduled C-section ❏ emergency C-section

Complications During Pregnancy: ❏ **No** ❏ **Yes** **Explain:** ______________________________

Medication During Pregnancy / Delivery: ❏ **No** ❏ **Yes** **List:** ______________________________

Ultrasounds During Pregnancy: ❏ **No** ❏ **Yes** **How Many:** ____________ **Cigarette / Alcohol Use during Pregnancy:** ❏ **No** ❏ **Yes**

At how many week's was your child born? ___________ Obstetrician / Midwife's Name: ______________________________

Please, let us know if any interventions or complicates were utilized:

❏ Breech Induction ❏ Pain Meds ❏ Epidural ❏ Episiotomy ❏ Vacuum Extraction ❏ Forceps ❏ Medical Induction ❏ Pitocin

Breastfed ❏ No ❏ Yes If yes, how long: ______ **Did they ever use formula?** ❏ No ❏ Yes At what age? ______ What type? __________

Frequently arch their neck / back, feel stiff or bang their head? ❏ No ❏ Yes Explain: ______________________________

What age: Respond to noise: __ Follow objects: __ Hold head up: __ Vocalize: __ Teethe: __ Sit: __ Crawl: __ Walk: __ Start cow's milk: __ & solid food: __

CHILD'S PAST TRAUMATIC HISTORY

List any past AUTO collisions / dates: ______________________________ **Was any care received?** ______________

List any past sport, recreational or home injuries: ______________________________

Please list child's HOSPITALIZATION and SURGICAL history, include year: ______________________________

Any MAJOR INJURIES, ACCIDENTS, FALLS or FRACTURES and dates: ______________________________

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