Funnell Family Chiropractic Child Entrance Form (Age 2 – 12)

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient name: _____ Today's date_____

Date of birth: _____ Age: _____ Sex: Male / Female (Please circle)

Address: _____

Postal address if different: _____

Phone: Home: _____ Business (Please include contact name):_____

Mobile: _____ Email address: _____

Names of Parents/Guardians: _____

School attended: _____

Name of person who referred you (e.g. Midwife, friend…)? _____

Previous Chiropractor: _____ Date of last visit: _____

Name of Medical Doctor: _____

Birth History:

□ Forceps □ Vacuum extraction (Ventouse) □ Normal vaginal □ Breech

□ Caesarian section: Emergency / Planned? (Please circle which)

Complications during delivery? □ Yes □ No Please list: _____

Genetic disorders or disabilities: □ Yes □ No Please list: _____

Birth weight: _____ APGAR Scores: _____

Health History:

Check any of the following conditions your child has experienced:

□ Ear infections	□ Scoliosis	□ Seizures	□ Chronic Colds	□ Headaches
□ Asthma/Allergies	□ Digestive Problems	□ ADHD	□ Constipation	□ Growing/Back Pains
□ Colic	□ Bed Wetting	□ Car Accident	□ Temper Tantrums	□ Other _____

_____

Number of courses of antibiotics your child has taken: In the last six months: _____, Total during lifetime: _____

Please list other prescription medications taken: _____

Have you chosen to have your child vaccinated? □ Yes □ No

Has your child had surgery: □ Yes □ No If yes, please list: _____

Has your child been diagnosed as having Congenital Hip Dislocation (Clicky Hips)? □ No □ Yes

Has your child had any spinal x-rays taken? □ Yes □ No

Has your child ever had any broken bones/fractures? □ Yes □ No Please List: _____

_____

Accident History:

Is / has your child been involved in any high impact or contact type sports (i.e. soccer, rugby, gymnastics, martial arts etc.)?

Please list: _____

Please list any accidents your child has had: _____

_____

_____

Is there anything you think we should know about your child or their health? _____

_____

_____

_____

Please state the reason for your visit to us today: _____

_____

Do you have a preferred appointment time? Yes/NoWhen? _____

On your visit today you will see the Chiropractor for a consultation; they will check your child's spine and gently make any chiropractic adjustments if necessary.

Authorization for care of a minor

I hereby authorize this office and its Chiropractors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Parent/Guardian: _____

Signed: _____ Date: _____

Thank you for taking the time to complete this form.

We look forward to helping your child achieve the best possible health with chiropractic.

We are here to serve you, and encourage you to ask questions.

Your participation is vital and will help determine your results.

Please ensure your mobile phone is switched off.