

APPLICATION FOR CARE AT CORRECTIVE CARE CHIROPRACTIC Child (CCC)

PATIENT INFORMATION

Name: _____ Birth Date: ____/____/____ Age: _____ Male Female
Social Security #: _____
Address: _____ City: _____ State: _____ Zip: _____
Father: _____ Mother: _____
Home Phone: _____ Mobile Phone: _____
_____ / _____

Who referred you to our clinic?
: _____

HISTORY OF COMPLAINT

Please identify if you came to this office, not as a result of a complaint, but for wellness care by completing the following: **Your Goals of Wellness Care:**

Please identify, if any complaints, injury or illnesses that brought you to this office:

When did these problem(s) begin? _____ is your child's problem(s) the result of ANY type of accident. Yes No

If yes identify type: Auto Home Other (please explain): _____
Date of Accident: _____

Has your child suffered with any of this or a similar problem(s) in the past? No Yes
If yes, when _____

Please state what type of treatment your child has tried for this problem(s):

Who provided it: _____ When? _____
What were the results? Favorable Unfavorable → please explain: _____

Is your child currently taking any medications? PLEASE LIST:

***PLEASE MARK** the areas on the Diagram with the following letters to describe your child's symptoms: **R=Radiating B=Burning D=Dull A=Aching**

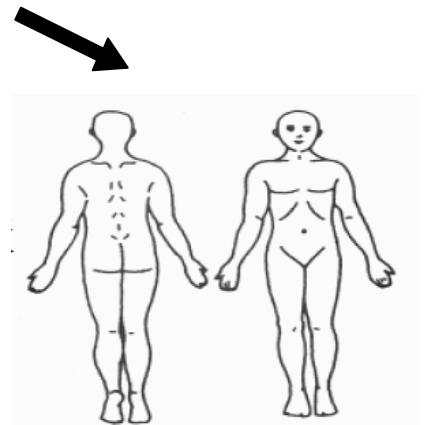
S=Sharp/Stabbing T=Tingling N=Numbness

What percentage of the day does your child experience symptoms: _____%

What relieves the symptom(s)? _____
What makes them feel worse? _____

Has your child had previous chiropractic care? Yes No
Name of previous Chiropractor: _____
What were the results? _____

On a scale of 1 to 10 with 10 being the worst pain and 0 being no pain,
Rate how you feel today (**Circle the number**):
0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10



PAST HISTORY

If your child has ever been diagnosed with any of the following conditions please indicate with a **P** for in the **Past**, **C** for **Currently** have and **N** for **Never** have had a:

- Disability Broken Bone Fracture Dislocations Tumors Diabetes
- Heart Attack Rheumatoid Arthritis Osteo Arthritis Cerebral Vascular
- Other serious conditions:

PLEASE, identify ALL PAST and any CURRENT conditions you feel may be contributing to your child's present problem:

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? No Yes, if yes whom:
 grandmother grandfather mother father sister(s)
 brother(s) son(s) daughter(s)
Have they ever been treated for their condition? No Yes I don't know
2. Any other hereditary conditions the doctor should be aware of. No Yes:

I hereby authorize payment to be made directly to Corrective Care Chiropractic for all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Corrective Care Chiropractic.

I request the clinic to submit claims to this insurance company:

Please provide your insurance card to us for copying. We will determine eligibility.

Patient or Authorized Person's Signature

Date

CONSENT TO TREAT A MINOR

MINOR PATIENT'S NAME: _____

The risks associated with exposure to ionization, and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor, and after careful consideration I do hereby request, and authorize Corrective Care Chiropractic to perform imaging studies, and chiropractic adjustments, to my minor child, for whom I have the legal right to select, and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse /former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way I will immediately notify this office.

Parent /Legal Guardian

Date