Confidential Health Information:
Care Chiropractic 134 Executive Drive #3
Lafayette IN 47905
(765) 448-6489

_______________ Patient Number

____/_____/______ Today's Date

______________________ Last Name

______________________ Social Security Number

___/_____/___ Birthdate

_______ Age

______________________ First Name

______________________ Middle Name (Initial)

Male_____Female
Gender

______________________________________ Address

Married Single Divorced Widowed
Marital Status

______________ City

________ State

__________ Zip Code

________________ Email

______________ Home Phone

______________ Cell Phone

______________________ Best time and place to reach you

Would you like to receive appointment reminders by **email** or **text** ? Cell Carrier: ____________

______________________ Employer

______________________ Occupation

______________________ Spouses Name

______________________ Whom may we thank for referring you ?

______________________ Insurance Carrier

______________________ Insured's Last Name

___/___/___ Birth Date

______________________ Member ID Number

______________________ Group Number

Self____Spouse____Parent
Who carries this policy?

If you are covered by additional insurance please indicate : ______________________________

Assignment and Release

I certify that I, and /or my dependent(s) have insurance coverage with __________________________
And assign directly to Care Chiropractic / Williams Chiropractic Corporation all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named clinic may use my health care information and may disclose such information to the above named insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

______________________________________ Signature of Patient, Parent, Guardian, Representative

______________________________ Relationship to Patient

______________________________________ Printed Name of Patient, Parent, Guardian, Representative

______________________________ Date

PEDIATRIC HISTORY FORM

PATIENT NAME:______________________________ S.S. #______________________________

ADDRESS:______________________________________ CITY______________________________

STATE:__________ ZIP:__________ HOME PHONE:______________________________

BIRTHDATE:_____/_____/_____ CELL PHONE:______________________________

SEX:____________ WEIGHT:__________ HEIGHT:__________

NAMES OF PARENTS / GUARDIANS:____

PURPOSE FOR CONTACTING US?

____

OTHER DOCTOR'S SEEN FOR THIS CONDITION:__________Y__________N, DOCTOR'S NAMES & PRIOR

TREATMENTS:____

OTHER HEALTH PROBLEMS?____

FAMILY HISTORY:____

PREVIOUS CHIROPRACTOR:____
DATE OF LAST VISIT:____/____/____REASON______________________________________

NAME OF PEDIATRICIAN:____
DATE OF LAST VISIT:____/____/____REASON:______________________________________
ARE YOU SATISFIED WITH THE CARE YOUR CHILD RECEIVED THERE? Y/ N

NUMBER OF DOSES OF ANTIBIOTICS YOUR CHILD HAS TAKEN:
DURING THE PAST 6 MONTHS:________, TOTAL DURING HIS / HER LIFETIME:________

NUMBER OF DOSES OF OTHER PRESCRIPTION MEDICATIONS YOUR CHILD HAD TAKEN:
DURING THE PAST 6 MONTHS:________, TOTAL DURING HIS / HER LIFETIME:________

VACCINATION HISTORY:____

PARENTAL HISTORY:

NAME OF OBSTETRICIAN / MIDWIFE:____

COMPLICATIONS DURING PREGNANCY?______Y______N, LIST:______________________________

COMPLICATIONS DURING DELIVERY? ______Y______N, LIST:______________________________

ULTRASOUNDS DURING PREGNANCY? ______Y______N, NUMBER________

MEDICATIONS DURING PREGNANCY / DELIVERY?______Y______N, LIST:______________________

LOCATION OF BIRTH: __________HOSPITAL__________BIRTHING CENTER__________HOME

BIRTH INTERVENTION: _____FORCEPTS_____VACUUM EXTRACTION _____CESSARIAN SECTION, EMERGENCY OR PLANNED?

APGAR SCORES:________,________ CIGARETTE / ALCOHOL USE DURING PREGNANCY: Y / N

GENETIC DISORDERS OR DISABILITIES:______Y______N, LIST:____

BIRTH WEIGHT:__________ BIRTH LENGTH:__________

FEEDING HISTORY:

BREASTFED: ______Y______N, HOW LONG:________

FORMULA: ______Y______N, HOW LONG:_______, TYPE:____

INTRODUCED: SOLIDS AT______MONTHS, COWS MILK AT_____MONTHS

FOOD / JUICE ALLERGIES OR INTOLERANCES:_____N_____Y, LIST:____________________________________

DEVELOPMENT HISTORY:

AT WHAT AGE WAS YOUR CHILD ABLE TO:

______RESPOND TO SOUND
______RESPOND TO VISUAL STIMULI
______HOLD HEAD UP
______SIT UP
______CROSS CRAWL
______STAND ALONE
______WALK ALONE

ACCORDING TO THE NATIONAL SAFETY COUNCIL, APROXIMATELY 50% OF CHILDREN FALL FROM A HIGH PLACE DURING THEIR FIRST YEAR OF LIFE (i.e. A BED, CHANGING TABLE, DOWN STAIRS, ETC.). WAS THIS THE CASE WITH YOUR CHILD?_____Y_____N

IS / HAS YOUR CHILD BEEN INVOLVED IN ANY HIGH IMPACT OR CONTACT TYPE SPORTS (i.e. SOCCER, FOOTBALL, GYMNASTICS, BASEBALL, CHEERLEADING, MARTIAL ARTS, ETC.)?_____Y_____N, LIST:____

HAS YOUR CHILD EVER BEEN INVOLVED IN A CAR ACCIDENT?_____Y_____N, LIST:___________________

HAS YOUR CHILD BEEN SEEN ON AN EMERGENCY BASIS?_____Y_____N, LIST:________________________

OTHER TRAUMAS NOT DESCRIBED ABOVE?_____Y_____N, LIST:_____________________________________

PRIOR SURGERY:_____Y_____N, LIST:____

CHILDHOOD DISEASES:

CHICKEN POX	Y / N, AGE______	MUMPS	Y / N, AGE:______
RUBELLA	Y / N, AGE______	WHOOPING COUGH	Y / N, AGE:______
RUBEOLA	Y / N, AGE______	OTHER	Y / N, AGE:______

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTORS 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.

SIGNED:___________________________________WITNESSED:________________________DATE:____/____/____