Nicolai Chiropractic Center – 7- to 15-year-old Case History

PLEASE PRINT *Use Legal Names – no nicknames* Date: _____

Child's Name: _____ Social Security #: _____
Last First Middle

Birth Date: _____ Age: _____ Gender: _____

Father's Name: _____ Social Security #: _____
Last First Middle

Mother's Name: _____ Social Security #: _____
Last First Middle

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

HOME PHONE: _____ MOTHER'S CELL: _____ FATHER'S CELL: _____

Mother's Employer & Address: _____ Work Phone: _____

Father's Employer & Address: _____ Work Phone: _____

Insurance: _____ Policy #: _____ Name On Card: _____

Insurance: _____ Policy #: _____ Name On Card: _____

Insurance Policy Holders Date of Birth_____

Who Were You Referred By? _____

Congenital Anomalies/Defects: _____

Pediatrician/Family MD: _____ Location: _____

Last visit to MD: _____ Purpose: _____

Immunization History: _____

Reason for consulting our office: _____ Prior Chiropractic care? Y/N

Any Emergency medical treatments? Y/N Describe: _____

_____

_____

List any falls or accidents: _____

_____

List any surgeries: _____

How many rounds of antibiotics have been taken in the last 6 months? _____

Present medications: _____

_____

Past medications: _____

Do you participate in: ___Football ___Rodeo ___Horses ___Basketball ___Volleyball

___Racing Other sports/hobbies _____

Diseases: ___ Chicken Pox ___ Rubella ___Rheumatic ___ Mumps ___Rubeola

___ Whooping Cough ___Measles ___Tuberculosis ___ Other

Present Health History: _____

_____

OVER PLEASE

7 TO 15 YR CASE HISTORY CONT'D

Do you use:	Heavy	Moderate	Light	None
Alcohol	____	____	____	____
Coffee	____	____	____	____
Soda	____ 3 or more	____ 1-2 cans	____ Occasional	____
Tobacco	____	____	____	____
Exercise	____	____	____	____
Water Intake	____ 6-8 glasses	____ 4-6 glasses	____ 1-4 glasses	____

Check the following that apply:

____ Dizziness	____ Backaches	____ Heart Troubles	____ Chronic Earaches
____ Diabetes	____ "Growing Pains"	____ High Blood Pressure	____ Colds/Flu
____ Arthritis	____ Headaches	____ Asthma	____ Allergies
____ Neuritis	____ Nosebleeds	____ Sinus Trouble	____ Constipation
____ Anemia	____ Heart Burn	____ Orthopedic Problems	____ Diarrhea
____ Poor Appetite	____ Hyperactivity	____ Sugar Concentration	____ Behavioral Problems
____ Bed Wetting	____ Convulsions	____ Paralysis	____ Muscle Jerking
____ Fainting	____ Walking Problems	____ Broken Bones	____ Ruptures/Hernias
____ Neck Problems	____ Arm Problems	____ Leg Problems	____ Other
____ Joint Problems	____ Blood Disorders	____ Stomach Aches	____ Other

Family History: _____
_____
_____
_____

AUTHORIZATION FOR CARE OF MINOR CHILD *RELEASE OF INFORMATION

I herby authorize this clinic and its doctors to administer care as they so deem necessary to my Son/Daughter/Ward (upon approval of parent or guardian).

I authorize the release of information from the patient's records to doctors, hospitals, or others for continuous care and to any third party who requires information to fulfill an obligation benefitting the patient. I authorize payment to Nicolai Chiropractic from the patient's insurance company(s) and/or Medicare.

Nicolai Chiropractic Center will process insurance claims. However, I realize that I am responsible for all the charges incurred during treatment. X-rays remain property of this clinic.

Signed:

_____Date:_____

Parent or Legal Guardian

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