NETWORK FAMILY WELLNESS CENTER

Network Family Wellness Centers
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CHILD NEW PATIENT APPLICATION
WELCOME TO OUR OFFICE. WE THANK YOU FOR YOUR TRUST!

(Please print using black or blue ink. If there is something that does not apply to you please put N/A on the line.)

Section 1: Patient Information **Appt. Date:** ________________ **Referred *By:*** ____________________

Name (first, middle, last):____

Preferred Name: ___________________________ ☐ Male ☐ Female Date of Birth: ___/__/_____ Age: _______

Address: ____ City: _______________ State: _____ Zip: __________

Cell Phone: _______________ /Carrier ________ Home Phone: ________________ Work Phone: __________________

Social Security Number: ____________________ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow

Employer: ____________________ Occupation: ___________________ Email: _________________________________

Name of Spouse/Significant Other: ______________ Name & Ages of Children: _______________________________

Emergency Contact: ______________________ Relationship____________________ Phone # (____) _________________

To conserve resources, we generally utilize Email and text for regular communication.

May we communicate with you via Email? ☐ Yes ☐ No | Text ☐ Yes ☐ No

1. Most patients are reffered to our office by a caring family member or friend. What made you decide to visit our office?

Friend/Family Member Name:___________________________

☐ Telephone Call ☐ Yellowpages ☐ Sign ☐ Website ☐ Presentation ☐ E-mail

2. Spinal problems can cause a variety of health problems. Please check the health complaint(s) your child is currently expereincing or experiences on a periodic basis:

☐ Neck Pain	☐ Asthma	☐ Frequetnt Colds	☐ Skin Problems
☐ Back Pain	☐ Allergies	☐ Spinal Curvature	☐ Chronic Fatigue
☐ Headaches	☐ Sinus Problems	☐ Indigestion	☐ ADD/ADHD
☐ Bedwetting	☐ Ear Infections	☐ Arthritis	☐ ________________

2. What is your child's primary health concern? ____

3. Research shows that spinal problems often begin at birth. How old was your child when they received their first chiropractic checkup? ☐ Never ☐ 0-2 Years ☐ 2-5 Years ☐ 5-12 years

4. Difficult, long and/or doctor-assisted births can cause spinal misalignments. Was your child born vaginally, by C-section, forceps, suction cup or other device? (Please circle one)

5. How long was the actucal labor and delivery time? ☐ 0-3 hours ☐ 3-12 hours ☐ 12-24 hours ☐ >24 hours

6. Have you ever been told that your child has a spinal curvature, apinal arthritis or onherited spinal problem?
☐ Yes ☐ No

7. Poor posture can lead to poor health and usually indicates a spinal problem. How would you rate youre child's posture?

Poor ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Very Good

8. Did your child have early health challenges such as colic, irritability or frequent ear infections? ☐ Yes ☐ No

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9. Does your child have other health problems that concern you? ____

10. Do you miss work or sleep often due to our child's illness(s)? ☐ Yes ☐ No

11. Do you worry often about your child's health? ☐ Yes ☐ No

12. Do you have any health problems that affect your family? Please list: ____

____

13. Is your child currently taking prescription medication? ☐ Yes ☐ No If so, how many?______________________

14. Falls, sports impacts and auto accidents can cause serious spinal problems. Is this visit related to a fall, sports impact, auto accident or injury? ☐ Yes ☐ No Date of Incident: ________________________

15. If the doctor feels that your child will benefit from chiropractic care are you willing to follow his/her recommendations?

☐ Yes ☐ No

Section 2: History of Concern

Primary Concern(s): ____

Secondary Concern(s): ____

Tertiary Concern(s): ____

Auto and work-related injuries can cause serious spinal problems. Are your complaints due to an Accident? ☐ YES ☐ NO

If yes, what type? ☐ Work ☐ Auto ☐ Personal Date of Accident____________________ If Work or Auto accident, have you reported this accident to anyone? ☐ Yes ☐ No Who was it reported to? _______________________

Have you seen any doctors for this condition: ☐ YES ☐ NO

Please list the doctor specialty, & for how long you were seen. ____

____

Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking? (Prescription and non-prescription)

____

____

Section 3: Family History:

Does anyone in your family suffer with the same condition(s) or other chronic illnesses? ☐ No ☐ Yes

If yes whom & what condition(s): ____

____

The above information is true and accurate to the best of my knowledge. Copies of any x-rays and reports will be released upon written request, however original x-rays remain the property of the clinic.

Patient/Guardian's Signature: ____Date: _____/______/__________

Doctor's Signature ____ Date Form Reviewed: _____/______/__________

Patient Name ____ DOB:________________________

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Section 4: Past Trauma History: *Starting from birth, we all experience thousands of physical, mental, & chemical stresses. These stresses can cause* ***Postural Distortions*** *(misalignments of the spine) and lead to our current health problems.*

Please write down some of the falls, injuries, & traumas that you've experienced. (Please put NA if it doesn't apply to you)

A. Car Accidents (List even minor ones. A 5mph crash from a 3000lb vehicle can cause damage to your spine even if you didn't ***feel*** injured!)

Example: 12-1-2007 ***Type of Collision:*** **Front end** **10 mph** ***Injuries:*** **Neck Whiplash/Neck on Rt. side**

Date:___/__/_____ Type of Collision: ☐ Front ☐ Side ☐ Rear Speed__________ Injuries: ____________________ ☐Lt ☐Rt

Date:___/__/_____ Type of Collision: ☐ Front ☐ Side ☐ Rear Speed__________ Injuries:____________________ ☐Lt ☐Rt

B. Sports Injuries (if there are too many to list please write the name of the sport and "MANY" next to it.)

Example: **1-1-2008** ***Type of Sport:*** **Basketball** ***Type of Injury:*** **Sprained Right Knee**

Date:___/__ /_____ Type of Sport______________ Type of Injury: ______________________________ ☐ Lt☐Rt

Date:___/__ /_____ Type of Sport______________ Type of Injury: ______________________________ ☐ Lt☐Rt

C. Slips, falls, & Bike Accidents (We understand there may have been a lot of slips & falls since birth, so please list the major ones.)

Example: 2-1-2008 ***Type of Injury:*** **Slipped on ice & bruised Left Elbow**

Date:___/__ /_____ Type of Injury:____ ☐ Lt☐Rt

Date:___/__ /_____ Type of Injury: ____ ☐ Lt☐Rt

D. Repetitive Injuries (Please list **all** repetitive injuries you've had in the past.)

Example: 3-1-2008 ***Type of Injury:*** **Lifting boxes injured lower back**

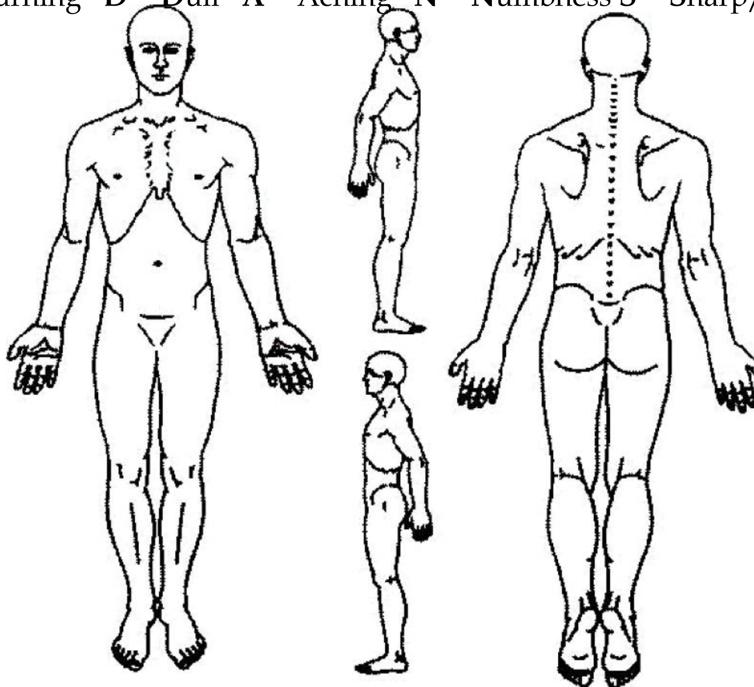
Date:___/__ /_____ Type of Injury: ____ ☐ Lt☐Rt

Date:___/__ /_____ Type of Injury: ____ ☐ Lt☐Rt

Exam

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling



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Patient Name ____________________________________ DOB:__________________

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Section 5: Present and Past Conditions

Using the codes listed below, please fill in ***EVERY*** blank with the applicable letter.

Check to indicate if you have Pain or Stiffness and on which side of your body.

If ***both*** sides apply, please check ***R & L*** .

P = Past Health Issue **C** = Current Health Issue **N** = Never had this Health Condition

Example: C Shoulder ☑ Pain ☐ Stiff ☑ R ☐ L

Extremities	Location	Respiratory	Other Conditions	Male
___ Hip ☐ Pain ☐ Stiff	☐ R ☐ L	___ Asthma	___ Headaches / Migraines	___ Impotence
___ Knee ☐ Pain ☐ Stiff	☐ R ☐ L	___ Chest Pain	___ Trouble Sleeping	___ Prostate Problems
___ Foot ☐ Pain ☐ Stiff	☐ R ☐ L	___ Difficulty Breathing	___ Excessive Sweating	**Female**
___ Shoulder ☐ Pain ☐ Stiff	☐ R ☐ L	___ Lung Problems	___ Cancer & Type: ___________	___ Menopausal Problem
___ Elbow ☐ Pain ☐ Stiff	☐ R ☐ L	___ COPD	___ Emotional / Mental Disorders	___ Menstrual Cycle Problems
		Digestion	___ Learning Disability	
___ Wrist ☐ Pain ☐ Stiff	☐ R ☐ L	___ Heartburn	___ Nervous / Irritable	
___ Jaw Pain ☐ Click ☐ Pop	☐ R ☐ L	___ Digestion Problems	___ Loss of Memory	**Social History**
___ Swollen or Painful Joints		___ Gallbladder Problems	___ Dizziness / Loss of Balance	
Spine		___ Colon Trouble	___ Arthritis	____ Smoking
___ Head / Shoulders Feel Heavy / Tired		___ Diarrhea / Constipation	___ Epilepsy / Convulsions	How much ___________
___ Neck ☐ Pain ☐ Stiff	☐ R ☐ L	___ Hemorrhoids	___ Knocked Unconscious	How Often ___________
___ Upper Back ☐ Pain ☐ Stiff	☐ R ☐ L	**Immune System**	___ Frequent Ear Infections	
___ Mid Back ☐ Pain ☐ Stiff	☐ R ☐ L	___ Skin Problems	___ Ringing in Ear R / L	____ Alcoholic Beverage Consumption
___ Low Back ☐ Pain ☐ Stiff	☐ R ☐ L	___ Sinus Problems/ Allergies	___ Hearing Loss R / L	Occurs______________
___ Pain with cough, sneeze, or strain with bowel movement LOCATION of Pain:______________		___ Frequent Colds / Flu	___ Trouble Concentrating	____Recreational Drugs
		___ Anemia	___ AIDS / HIV	What Used___________
Other:_______________________________ _______________________________		___ Other: _______________	___ Fracture / Dislocation of Bones: _______________________	How Often___________
		Organ Problems or Dysfunction	___Other: _______________ _______________________	____Exercise
Numbness / Tingling or Pain In:		___ Diabetes	**Urinary Tract**	Type_______________
___ Arm	☐ R ☐ L	___ Liver Trouble	___ Kidney Trouble	How Often___________
___ Hand /Fingers	☐ R ☐ L	___ Hepatitis	___ Frequent Urination	
___ Legs	☐ R ☐ L	___ High/Low Blood Pressure	___ Bedwetting	
___ Foot / Toes	☐ R ☐ L	___ Heart	___ Other:_______________	

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Doctor's Signature ____________________________________ Date Form Reviewed: _____/______/__________

Patient Name _____________________________________ DOB:_____________________

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Section 6: Past Health Conditions

Transfer conditions from page 3 marked with a "P" for past health issue.

Please list: *when, how long it lasted, description of symptoms (ex. Sharp, pain, burning), how often (ex. Weekly, daily), severity (0=no pain; 10=worst pain)* .

Past Health Issue: ____

____

Past Health Issue: ____

____

Past Health Issue: ____

____

Are any of these past conditions due to an accident? ☐ YES ☐ NO If yes, what type? ☐Work ☐Auto ☐ Personal

Date of Accident_________________ Have you seen any doctors for this condition: ☐ YES ☐ NO

Please list the doctor specialty, & for how long you were seen. ______________________________

List any past hospitalizations and/or surgeries:

Surgeries: ____

List Hospitalizations Other Than Surgeries: ______________________________

The above information is true and accurate to the best of my knowledge. Copies of any x-rays and reports will be released upon written request, however original x-rays remain the property of the clinic

Patient/Guardian's Signature: ______________________________Date: _____/______/__________

Doctor's Signature ______________________________ Date Form Reviewed: _____/______/__________

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