NEW LIFE CHIROPRACTIC

Health Profile for Minors

C S W

Date: _____/_____/_____

Name: _____ Date of Birth: _____/_____/_____ Age: _____ M / F

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

Home Phone: _____ Cell: _____ Carrier (i.e. AT&T): _____

Email Address: _____

How do you prefer to receive reminders? TEXTS / EMAIL / PHONE CALL

Social Security #_____-_____-_____ Parents SS #_____-_____-_____

Do you have insurance? ___YES ___NO Name of Insurance Company: _____

Who may we thank for referring you? _____

PLEASE LIST YOUR HEALTH CONCERNS:

Health Concerns?	Rate of Severity 1 = Mild; 10 = Unbearable	When Did It Begin?	How Did It happen?	Did the Problem Begin with an Injury?	Are Symptoms Constant or On and Off?

What health goals would you like to accomplish through chiropractic care?

_____

_____

If you are experiencing pain, is it: ____ SHARP ____ DULL

Does the pain travel or radiate anywhere? ____ YES ____ NO

If YES, please describe: _____

_____

Since your problem started, is it: ____ ABOUT THE SAME ____ GETTING BETTER ____ GETTING WORSE

What makes it worse? _____

What makes it better? _____

What other doctors have you seen for this condition? ____ CHIROPRACTOR ____ MEDICAL DOCTOR ____ OTHER

List surgical operations and years: _____

_____

List all medications you are on: _____

_____

When was your last auto accident? _____

Have you had previous chiropractic care? ____ YES ____ NO

If YES, list most recent date and doctor's name: _____

Have you ever been unconscious? ____ YES ____ NO Have you ever fractured a bone? ____ YES ____ NO

If YES to either, please describe: _____

_____

Have you had any other bodily trauma? _____

PLEASE CIRCLE ANY CONDITIONS YOU HAVE NOW OR HAVE HAD IN THE PAST:

Stroke Cancer Heart Disease Spinal Surgery Seizures Spinal Bone Fracture Scoliosis Diabetes

PLEASE CIRCLE ANY AND ALL ISSUES YOU HAVE HAD WITHIN THE LAST TWO YEARS:

Asthma	Arthritis	TMJ	Chronic Fatigue
Epilepsy	Gastric Reflux	Heart Disorders	Lupus
Ulcers	Sciatica	Irritable Bowel	Nausea
Dizziness	Numbness in Arms	Disc Problems	Menstrual Disorder
Kidney Problems	Numbness in Legs	Liver Disease	Neck Pain
Headaches	Numbness in Hands	Low Back Pain	Migraines
Vertigo	Numbness in Feet	Mid Back Pain	Stiffness in Neck
Chest Pains	Ear Infections	Stomach Disorder	Hip Pain
Arm Pains	Grating in Neck	Leg Pain	Anxiety
Nervousness	Shoulder Pain	Fainting	Chronic Sinus

Other: _____

LIST SYMPTOMS/COMPLAINTS IN ORDER OF MOST DISCOMFORT:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

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Written Consent for a Minor

Name of Minor: _____

I authorize Dr. Jacob Sims, Dr. Laura Sims, and/or Dr. Tara Madden as well as any and all New Life Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care, and perform chiropractic adjustments to my minor child.

As of this date, I have the legal right to select and authorize health care services for my minor child. If my authority to select and authorize care is revoked or altered, I will notify New Life Chiropractic prior to further services.

_____ _____

Date Guardian Name (PRINT)

_____ _____

Team Member Signature Guardian Signature

_____

Guardian's Relationship to Minor