3311 Bethel Rd. SE, Suite 6A Port Orchard, WA 98366

For Office Use Only
Acct#_____
Claim#_____

ABOUT THE CHILD

Last Name: _____ First Name: _____ Middle: _____
Gender: □M □F Date of Birth: __/__/__ Age: _____ Height _____ Weight _____
Home Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____ Home Phone #: _____
Parent's Name _____ Parent's Work Phone #: _____ Cell Phone #: _____
Occupation: _____ Parent's Employer Name: _____
Employer Address: _____ City _____ State _____ Zip _____

SPOUSE or GUARDIAN

Last Name: _____ First Name: _____ Middle: _____
Employer Name: _____ Work Phone #: _____
Date of Birth: __/__/__ Social Security #: _____

REASON FOR THIS VISIT

Describe the purpose of this visit
Is the purpose of this appointment related to:
□ Sports □ Auto □ Fall □ Chronic Discomfort □ Home Injury □ Other
Please Explain: _____

Has this condition □ Gotten worse □ Stayed constant □ Comes and goes
Does this condition interfere with: □ Other Activities □ Sleep □ Daily Routine
Explain: _____

Has this condition occurred before? □ Yes □ No
Please Explain: _____

Have you seen other doctors for this condition?
□ Yes □ No Dr's Name: _____ Type of Treatment _____

MOTHER'S PREGNANCY & LABOR

During pregnancy, did the mother:

- Take any medication? □ Yes □ No
- Smoke or consume alcohol? □ Yes □ No
- Experience any illness? □ Yes □ No

Approximately how long did labor last? _____ Hours
Was labor chemically induced? □ Yes □ No
Was labor doctor assisted? □ Yes □ No
Was a C-Section performed? □ Yes □ No
Were forceps or vacuum extraction used? □ Yes □ No
Did the delivery doctor pull or twist the baby during delivery? □ Yes □ No

For Office Use Only
Acct#_____
Claim#_____

Was the delivery premature? □ Yes □ No If "Yes", at_____month and_____weight
Check any of the following if the child experienced it immediately after birth.
□ Jaundice □ Respiratory Problems □ Feeding Problems □ Displaced/Broken Joints □ Other
Please Explain_____

CHILD'S CURRENT HEALTH STATUS

Is your child accident prone? □ Yes □ No
Has your child:

- Been hospitalized? □ Yes □ No
- Had a severe fall? □ Yes □ No
- Ever been in a car accident? □ Yes □ No

Has your child ever taken antibiotics? □ Yes □ No
If "Yes", Explain_____

Is your child **currently** taking any medication? □ Yes □ No
If "Yes", Explain_____

Does your child have difficulty interacting with schoolmates or friends? □ Yes □ No
Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior? □ Yes □ No
What changes (if any) in your child's health or behavior would you like accomplished?_____

GOALS FOR MY CHILD'S CARE

Children see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Dr. Jones will weigh your needs and desires when recommending your child's Chiropractic care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

□ **Relief Care** – Symptomatic relief of pain or discomfort
□ **Corrective Care** – Correcting and relieving the cause of the problem as well as the symptoms
□ **Comprehensive Care** – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

□ I Dr. Jones to select the type of care appropriate for my child.

_____
Parent/Guardian's Signature Date

VACCINATIONS

Have you chosen to vaccinate you child? □ Yes □ No If "Yes", check all vaccinations the child has received.
□ DPT □ MMR □ Polio □ Chicken Pox □ Hepatitis
□ Other _____
Describe any and all reactions to vaccine(s)._____

For Office Use Only
Acct#_____
Claim#_____

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

□ Severe or Frequent Headaches	□ Breathing Problems	□ Dizziness
□ Loss of Sleep	□ Irritability	□ Tubes in the Ears
□ Vision Problems	□ Skin Problems	□ Digestive Problems
□ Allergies	□ Asthma	□ Congenital Heart Defect
□ Hyperactivity	□ Constipation	□ Bed Wetting
□ Pink Eye	□ Ear Problems	□ Colic
□ Attention Problems	□ Frequent Colds	□ Rheumatic Fever
□ Psychiatric Problems	□ Other _____	

_____

_____

AUTHORIZATION TO CARE FOR A MINOR CHILD

I hereby authorize Dr. Jones to work with my child _____through the use of adjustments and procedures to the spine, as he deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. Dr. Jones will not be held responsible for any pre-existing medically diagnosed conditions nor for nay medical diagnosis. I also understand that if my child's care is suspended or terminated, any fees for professional services rendered will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered to my child.

_____ _____

Patient's Name (Print) Guardian or Parent's Name Authorizing Care (Print)

_____ _____ _____

Parent/Guardian's Signature Authorizing Care Date Witness' Signature

Who should receive bills for payment on your account?

□ Patient □ Parent □ Auto Insurance □ Personal Health Insurance

Ownership of X-ray Films

It is understood and agreed that the payments to Dr. Jones for X-rays is for examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

ABOUT MY INSURANCE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that JONES CHIROPRACTIC will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to JONES CHIROPRACTIC will be credited to my account on receipt.

Insurance Co. Name_____ Member ID#_____

Address_____ Member/Provider Services Phone #_____

ABOUT THE INSURED PERSON

Name_____ Insured's Social Security#_____

Relationship_____ Date of Birth_____

Employer_____