Valentini
CHIROPRACTIC

MERIDIAN CHIROPRACTIC

Minor Patient Intake

About the Child

Name_____
Birthdate_____ Age_____
Gender_____
Height_____Weight_____
Address_____
City/State/
Zip_____
Parent's
Name_____
Phone_____

Reason for the Visit

What brings you in today?

_____
_____
_____
_____

When did it start?_____
Has it gotten worse, better or stayed the same since it began?_____
Does it interfere with sleep, daily routine or other activities?_____
If yes, please explain

_____

Has this condition occurred before?

_____

If yes, please explain

_____

Have you seen other providers for this condition?_____
Dr.'s Name(s)

_____

Type of treatment

_____

Results_____

_____

Has your child:
....been hospitalized?_____
....had a sever fall?_____
....been in a car accident?_____

Minor's Health History

Please circle 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.

- Vision Problems
- Headaches
- Sleeping Disorders
- Irritability
- Skin Problems
- Allergies
- Breathing Problems
- Asthma
- Hyperactivity
- Constipation
- Bed Wetting
- Pink Eye
- Ear Problems
- Tubes in the Ears
- Attention Problems
- Frequent Colds
- Colic
- Digestive Problems
- Other_____
  _____
  _____

Vaccinations

Have you chosen to vaccinate your child?

_____

If yes, please circle all of the vaccinations your child has received.

- DPT
- MMR
- Polio
- Chicken Pox
- Hepatitis
- Other_____
  _____

4900 HWY 169 N, Suite #250
New Hope, MN 55428
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Mother's Pregnancy and Labor

During pregnancy, did the mother:
....take any medication?
_____ Please explain
_____
....smoke or consume alcohol?
_____
....experience any illness?
_____
Please explain
_____
Approximately how long did labor last?
_____hours
Was labor chemically induced?
_____
Was labor doctor assisted?
_____
Was a C-Section performed?
_____

Were forceps or vacuum extraction used?
_____
___
Did the delivery doctor pull or twist the baby during deliver?
_____
Was the delivery premature?
_____
If yes, at _____weeks and
_____weight

Circle any of the following if the child experienced it immediately after birth.

- Jaundice
- Feeding Problems
- Respiratory Problems
- Displaced or Broken Joints
- Other
  Conditions_____
  _____

Authorization to Care of a Minor

I hereby authorize the Doctors in this Chiropractic office, and whomever they may designate as their assistants to administer Chiropractic care, to work with my child (name) _____ through the use of adjustments and procedures as the Doctor deems appropriate.

I clearly understand and agree that all services rendered 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. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any 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 understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and policy holder. I understand that the Doctor's Office 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 the Doctor's Office will be credited to my account on receipts. I hereby authorize assignment of insurance rights and benefits (if applicable) directly to the provider for services rendered to my child.

_____ _____
Patient's Name Parent/Guardian's Name

_____ _____ _____
Parent/Guardian's Signature Date Witness' Signature

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