

ChiroEvolution
Pediatric New Practice Member Application
It's all about the uniqueness of your child

PATIENT INFORMATION

Patient Name: _____ **Date:** _____
DOB: _____ Age: _____ Sex: Male Female
Address: _____ City: _____ State: _____ Zip: _____
Home #: _____ Office #: _____ Cell #: _____
Where do you prefer to receive calls? Home Office Cell No preference
Whom may we thank for referring you to us? _____

RESPONSIBLE PARTY

Name of Person Responsible for Account _____
Relationship to Patient _____ Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____
Name of Employer: _____ Work #: _____

INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____
DOB: _____
Insurance Company: _____ Phone #: _____
Policy ID#: _____ Group#: _____
Insurance Co. Address: _____ City: _____ State: _____ Zip: _____
How much is your deductible? _____ How much is your copay? _____ Maximum Annual Benefit? _____

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly
Name of Insurance Carrier

To ChiroEvolution all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named office may use my health care information and may disclose such information to the above named Insurance Carrier and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Parent, Guardian or Personal Representative Date

Print Name of Parent, Guardian or Personal Representative Relationship to patient

Present Health Challenge(s):

For what health challenge(s) is your child here for?

What do you feel is the cause of your child's problem?

When did you first notice this sign of body dysfunction?

Is this dysfunction getting progressively worse? ___ Yes ___ No

If yes, why do you think so?

What are the most significant measures you have taken to date to improve your child's present health challenge?
Please list all the healthcare practitioner's seen, treatments rendered, and any results experienced.

Please list the (3) most significant stressful events in your child's life from the most recent to the most distant. Are any of these situations continuing to impact his/her life? If yes, please explain clearly.

Please list any and all other concerns regarding your child's health and whether or not you feel they are related to your child's primary reason for being seen in our office today.

___ Allergies	___ Frequent colds/ congestion	___ Upper respiratory Infections	___ Asthma
___ Ear infections	___ Infected/sore Throat	___ Tonsillitis	___ Laryngitis
___ Colic	___ Reflux/spitting up	___ U-tract infections	___ Poor appetite
___ Poor digestion/ (constipation/diarrhea)	___ Thrush mouth/ Chronic diaper rash	___ Eczema/psoriasis/ Other skin rashes	___ ADD/ADHD
___ Irregular sleep Patterns	___ Night terrors	___ Bed wetting	___ Headache
___ Anxiety	___ Mood swings	___ Bruising	

Did you know that the persistent use of antibiotics can lead to an early onset of gastrointestinal tract distress leading to overgrowth of intestinal yeast? Did you also know that chronic use of antibiotics can lead to antibiotic resistant bacteria?

Please list any and all prescription medications that your child is presently using and has used on more than one occasion. Please reflect carefully as your child's present health state may be related directly or indirectly to the treatment of a past problem.

Has your child ever been hospitalized? Yes No

If yes, why and when? (Please list in chronological order) _____

Accidental trauma is the number one cause of injury to children in the United States each year. Please list any and all injuries experienced by your child, how they occurred and what action was taken to correct them.

Please check any of the following sports activities that your child is engaged in.

<input type="checkbox"/> Football	<input type="checkbox"/> Lacrosse	<input type="checkbox"/> Soccer	<input type="checkbox"/> Track/Field
<input type="checkbox"/> Bowling	<input type="checkbox"/> Tennis	<input type="checkbox"/> Hockey	<input type="checkbox"/> Volleyball
<input type="checkbox"/> Baseball/Softball	<input type="checkbox"/> Skateboarding	<input type="checkbox"/> Snowboarding	<input type="checkbox"/> Skiing
<input type="checkbox"/> Gymnastics/Trampoline	<input type="checkbox"/> BMX/Motorcross	<input type="checkbox"/> Swimming	<input type="checkbox"/> Golfing

Has your child ever been injured while playing sports? Yes No

If yes, what type of injury(s) occurred? _____

Recent research reveals that 30% of American children are obese with more than 50% of all US children overweight.

On a scale from 1 – 5, please rate the food groups that are most eaten by your child on a daily basis. Use the higher number for the most common foods eaten.

__1 __2 __3 __4 __5	__1 __2 __3 __4 __5	__1 __2 __3 __4 __5	__1 __2 __3 __4 __5
<u>Non-Complex Carbohydrates</u> Bread Products, Cereals, Pizza, Cakes, Cookies, Chocolate, Candy	<u>Complex Carbohydrates</u> Fruits & Vegetables	<u>Protein</u> Nuts, Seeds, Meats, Eggs	<u>Fats</u> Dairy Products

Please list the (3) most common foods eaten by your child each day.

How many times per month does your child eat fast food? _____

What type? _____

What is the primary beverage consumed by your child? _____

How much water does your child drink each day? _____

Does your child drink soda? ___ Yes ___ No If yes, how much on a daily basis? _____

Does your child consume artificial sweeteners such as those found in sugarless, fat free products? ___ Yes ___ No
If yes, what type of artificial sweeteners does your child use? _____

Was your child breast fed? ___ Yes ___ No If yes, for how long? _____

Was your child formula fed? ___ Yes ___ No If yes, what type and for how long? _____

At what age did you introduce solid foods into your child's diet? _____ What type(s)? _____

Has your child exhibited any intolerance and/or allergy to any specific food? ___ Yes ___ No
If yes, please list all foods. _____

Has your child been tested for allergies? ___ Yes ___ No

If yes, how were the tests performed? _____

What were the results? _____

If your child does have an allergy, how does it present itself? (Skin rash, hives, ENT/respiratory, digestive symptoms)

Has your child received treatment for any type allergy? ___ Yes ___ No

If yes, what type of treatment?
