Binder Family Chiropractic LLC Child Registration & History Form

Patient Name: _____
Address: _____ City: _____
State: _____ Zip Code: _____
DOB: ____ / ____ / ____ Sex: _____ Weight: _____ Height: _____
Names of Parents / Guardians:
_____
Home Phone #: (_____)_____ Cell Phone #: _____
Email: _____
In Case of Emergency Contact: _____ Phone #: (_____)_____
Who should we thank for referring you?
_____

Has your child ever received Chiropractic care? ____**YES** ____**NO**

If yes, previous Chiropractor's name and date of last visit:
_____

Present Health Complains/Concerns

Major: _____

_____

Minor: _____

_____

Please check any of the current or past problems your child has had on the list below:

__Dizziness	__Asthma	__Bed Wetting	__Headaches
__ADHA	__Runny Nose	__Behavioral	__Frequent Colds
__Autism	__Itchy Eyes	__Allergies	__Neck Pain
__Backaches	__Fever/Chills	__Chronic Ear Infections	

When did this problem begin:
_____
_____

Is this problem (circle) **occasional** **frequent** **constant** **intermittent**

Does this problem radiate? ____**YES** ____**NO** If yes, where? _____

What makes this worse: _____

What makes this better: _____

Is the problem worse during a certain time of the day? ____**YES** ____**NO**

If yes, when: _____

Does this interfere with the child's (circle) **sleep** **eating** **daily routine**

Is this becoming worse: _____

Other professionals seen for this condition: _____

Medications prescribed for this condition:

_____

_____

Results with that treatment:

_____

_____

Has your child been injured in any type of accident (ie. Sports, car accident, major fall, etc)? __**YES** __**NO**
If yes, please describe with dates:

_____

_____

Prior surgeries? ____**YES** ____**NO** If yes, type and date:

_____

_____

Parent Signature: _____ Date: _____

Binder
FAMILY CHIROPRACTIC LLC