Welcome to Chiropractic USA!

Our purpose is to educate and adjust as many families as possible
toward optimal health through natural CHIROPRACTIC CARE !

CONFIDENTIAL PATIENT INFORMATION

Name_____Date_____
Mother's Name_____Father's Name_____
Address _____
City _____ State _____ Zip _____
Home Phone _____Cell Phone_____
Birth Date _____ Age: _____ Grade:_____

The vast majority of our patients have been involved in dozens of IMPACTS
that could cause **VERTEBRAL SUBLUXATION** (spinal misalignment).
The doctor wants to discover **5** of yours.

Please check if you now do or have done any of the following sports:

	now	past	#of years		now	past	#of years
Baseball	☐	☐	_____	Roller blade/skate	☐	☐	_____
Basketball	☐	☐	_____	Running/Track	☐	☐	_____
Bike riding	☐	☐	_____	Skateboard	☐	☐	_____
Dance	☐	☐	_____	Sledding/Ski	☐	☐	_____
Football	☐	☐	_____	Soccer	☐	☐	_____
Gymnastics	☐	☐	_____	Swim/Surf	☐	☐	_____
Hockey Ice or Field	☐	☐	_____	Tennis	☐	☐	_____
Horseback riding	☐	☐	_____	Trampoline	☐	☐	_____
Ice Skating	☐	☐	_____	Volleyball	☐	☐	_____
Martial Arts	☐	☐	_____	Wrestling	☐	☐	_____
Lacrosse	☐	☐	_____	Other _____	☐	☐	_____

Please list ALL automobile/motor vehicle accidents that occurred while you were a passenger…whether you felt hurt or not…if you do not remember the exact date write just the year or your age at the time of the accident.

Date – Age at accident	Speed	Location of impact	Any Treatment?
		Front Side Rear	
		Front Side Rear	
		Front Side Rear	

Reasons for Consulting our Office

Name:_____

Date_____

File# _____

- ☐ I have no specific health problem. This is a general checkup.
- ☐ I have a symptom or complaint.

Chief complaint: _____

When did your complaint appear? _____

Rate the severity (circle your level) 0 1 2 3 4 5 6 7 8 9 10

None Little Medium Severe

Describe (check all that apply):

☐ sharp ☐ burning ☐ achy ☐ throbbing ☐ dull

☐ stabbing ☐ shooting ☐ stiff ☐ tingling ☐ other:_____

How often do you have your chief complaint? _____

Is it constant or occasional? _____

What makes it worse? _____

What makes it better? _____

What have you done for this? _____

What surgeries have you had? _____

What medications do you take? _____

_____

Have you experienced or are you experiencing? (check all that apply)

- ☐ Neck pain / stiffness
- ☐ Shoulder Pain
- ☐ Arm / hand pain
- ☐ Upper / mid back pain
- ☐ Low back pain
- ☐ Depression
- ☐ Dizziness
- ☐ Leg Pain
- ☐ Hip / groin pain
- ☐ High Blood Pressure
- ☐ Stress
- ☐ High cholesterol

Does anyone in your household smoke? YES NO

Do you get ear infections? YES NO how often? _____

Do you miss school due to illness? YES NO how often? _____

Do you get headaches? YES NO monthly weekly daily

Have you ever fallen down stairs? YES NO how many times? _____

Have you ever fallen out of bed? YES NO how many times? _____

Have you fallen off playground equipment? YES NO how many times? _____

Do you wrestle with brothers/sisters/friends? YES NO

Do you wear a back pack? YES NO How much does it weigh?_____

Do you wear your backpack with both straps or carry on one side/shoulder?

The average child falls 3,000 times learning to walk during the first 3 years of life.

When learning to walk, did you fall? less than average about average more than average

Have you had any broken bones? _____ or sprains? _____

Do you have diabetes? _____ Type 1 or Type 2 how long? _____

Do you have asthma? _____ how long? _____

Do you have ADD or ADHD? _____ medication? _____

Name: _____
File# _____
Date_____

How many hours per day do you spend…

Hours	Less than 1	1 to 2	2 to 3	3 to 5	5 +
Watching TV					
Playing video games					
Sitting at a computer or desk					

Does it make sense how VERTEBRAL SUBLUXATI"ONS (spinal misalignments) are caused?
Vertebral subluxation affects your ***nervous system,*** which affects your ***health.***

Goal Question: If you could accomplish one important thing or mission for your life, what would that be ?

_____

_____

The very **first vertebral subluxation** can occur during the **birthing process**.

Was child born ? natural childbirth or C- Section

Was child born ? at home or at hospital

Was child born prematurely?

NO YES Briefly describe:_____

Any complications?

NO YES Briefly describe:_____

_____

_____

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment: _____

Are you insured? NO Mass Health BCBS Other_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Chiropractic USA will prepare any necessary reports and forms to assist me in making collection from the Insurance Company and that any amount authorized to be paid directly to Chiropractic USA will be credited to my account receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I understand that the fee paid for treatment X-rays is the cost of taking and reading the films. The film itself is the property of this office. Copies of these films (on CD) or any other records can be released with advanced request (usually 24 hrs.) and signed release.

Parent's Signature: _____ Date: _____

Thank you for taking the time to fill out this form as completely and accurately as possible.
This information is crucial to your child's case and the doctor will be reviewing it very carefully and correlating this information with his/her X-ray findings.
We look forward to helping you and your family toward optimal health.