Sea Change
Family Chiropractic, PLLC

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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: _____

e-mail:_____

Name of Employer: _____ Work #: _____

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'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the information on these forms to this office. I authorize this office and its staff to examine and treat my child/minor's condition as the doctors see fit. I authorize all of my child/minor's health care providers to release any treatment notes, diagnostic reports and/or surgery reports to Sea Change Family Chiropractic. Furthermore, I authorize Sea Change Family Chiropractic to release any treatment reports to a referring and/or co-treating physician as it corresponds with chiropractic care. This office may use the patient's health care information and may disclose such information to the insurer of this patient and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____
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 worse? ___Yes ___No If yes, why do you think so? _____

Please mark and X for any of the following that apply.

____ ADD/ADHD	____Frequent colds/ congestion	____Upper respiratory Infections	____Asthma
____Ear infections	____Colic	____Mood swings	____Anxiety
____Poor digestion/ (constipation/diarrhea)	____Reflux/spitting up	____Eczema/psoriasis/ Other skin rashes	____Poor appetite
____Irregular sleep Patterns	____Night terrors	____Bed wetting	____Headache
Other_____	Other_____	Other_____	Other_____

Please review the below listed symptoms and conditions and indicate those that are current health problems of a family member by the designation **C** under his or her column. The designation **P** should be used to indicate a past problem. Leave blank those spaces that do not apply

	Father Age____	**Mother** Age____	**Spouse** Age____	**Brother**(s) Age____ Age____		**Sister**(s) Age____ Age____		**Children** Age____ Age____ Age____		
First Name										
Condition										
Allergies/Sinus Problems										
Anxiety										
Arthritis										
Auto Accidents										
Back or Neck Pain/Disc Problems										
Cancer										
Diabetes										
Frequent Colds/Flus										
Gas/Bloating/Constipation/Diarrhea/ Acid Reflux										
Headache/Migraine										
Heart Problems										
High Blood Pressure										
Low Energy										
Sleeping Problems										
Other:										
Other:										

Has your child ever been adjusted by a chiropractor before? ____YES ____NO (
(If yes, what was the reason for those visits, Who was the Doctor, and When was the last visit?)

_____

_____

Who is your child's pediatrician? _____When was their last visit?_____

Has your child seen any other health professionals? *(If yes, who, when, and for what?)*

_____

_____

What does your child usually eat for:

BREAKFAST:_____

LUNCH: _____

DINNER: _____

SNACKS: _____

Is there anything else you feel we should know about your child?_____

_____

_____

_____

_____

_____

_____

_____