

SINGER FAMILY CHIROPRACTIC
YOUNG PERSON (ZERO TO 12 YRS)

Welcome to our office! Please complete **all** questions for your child.

Date: _____

Child's Full name: _____

Name he/she wishes to be called: _____ Date of Birth: _____ Age: _____

Mom's name: _____ Dad's Name: _____

Who may we thank for referring you? _____

Home address: _____ City: _____

Zip code: _____ Home phone number: _____

Parent Cell phone: _____

Parent's Work Number: _____ Parent E-mail: _____

Current health complaint(s)/Reason for consulting our office:

Circle any of the following problems your child has or has had since birth:

Vision Problems

Headaches

Allergies

Ear Infections

Attention Problems

Hyperactivity

Bed Wetting

Colic

Digestive Problems

Frequent Colds

Constipation

Sleeping Problems

Previous chiropractic care? Yes No Last visit: _____ Doctor's name: _____

Favorite hobbies or interests: _____

Your child's pediatrician? Name: _____

Number: _____

List operations your child has had:

Medications your child currently takes and *what they are for*:

Health Insurance

I authorize Dr. Lewis Singer to release any and all information he deems appropriate concerning my physical condition to my insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges as a result of professional services rendered and hereby release Dr. Singer and Singer Family Chiropractic of any consequences thereof.

Signature

Date

Child's Social security number (required): _____-_____-_____

Mother's Pregnancy and Labor

Did your child have a HOME birth, a HOSPITAL birth, or was birthed in a BIRTHING CENTER? _____

During pregnancy, did the mother:

a. take any medication? Yes No

Explain: _____

b. smoke or consume alcohol? Yes No

c. experience any illness? Yes No

Explain: _____

Approximately how long did labor last? _____ hours

Was labor chemically induced? Yes No

Was labor doctor assisted? Yes No

Was a C-section performed? Yes No

Were forceps used? Yes No

Was vacuum extraction used? Yes No

Did the delivery doctor pull or twist the baby during delivery? Yes No Unsure

Was the delivery premature? Yes No

Any problems your child experienced at birth? Yes No

Explain: _____

Child's Current Health Status

Is your child accident prone? Yes No

Has your child: been hospitalized? Yes No

had a severe fall? Yes No

been in a car accident? Yes No

Does your child have difficulty interacting with schoolmates or friends? Yes No

Is your child nervous or does he/she twitch, shake, or exhibits rocking behavior? Yes No

Vaccinations

Have you chosen to vaccinate your child? Yes No

If yes: All vaccinations Certain Ones

If Certain Ones, which? _____

Describe any and all reactions to vaccine(s): _____

X-ray/Radiographic Policy

Our practice of chiropractic involves the use of X-ray pictures or radiographs in most cases.

We at Singer Family Chiropractic take every precaution to produce safe and effective chiropractic X-rays. We only take those pictures that are necessary.

Our policy regards all X-rays/radiographs taken as part of your permanent medical record, not unlike our file folder that has all your information. **Any payment made for X-rays is made for the production and analysis of those pictures, not for the actual pictures themselves.** *All X-rays taken are the property of Singer Family Chiropractic and Dr. Lewis Singer. We do not release our films to our patients.*

If you would like a copy of your pictures, we have contracted with a copy service that can make those copies for you for a fee. Please talk with our front desk assistant if you would like copies made and she can relate to you all the details including cost.

Thank you for reading and understanding our office policy regarding X-rays.

I have read and understand the above policy:

Signature

Date

*Thank you for your time!
Dr. Lewis Singer*