SINGER FAMILY CHIROPRACTIC
YOUNG PERSON (ZERO TO 12 YEARS)

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:_____ State:_____ Zip Code:_____
Home Number:_____ Parent's Cell #: _____
Parent's Work Number: _____
Parent E-mail address:_____@_____ . _____

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

_____
_____
_____

Circle any and all 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

Other: _____

Previous Chiropractic care? Yes No Last Visit: _____ Doctor's Name: _____

Favorite hobbies and/or interests:_____

Your child's pediatrician: Name: _____
Phone Number: _____

List any and all operations your child has had:_____
_____

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

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 exhibit rocking behavior

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): _____
_____
_____
_____

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, Singer Family Chiropractic and all employees of any consequences thereof.

_____ _____

Signature Date

X-ray/Radiographic Policy

Our policy regards all X-rays/radiographs taken as part of your permanent medical record. **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.*

I have read and understand the above policy:

_____ _____

Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Signature Date