CHILD/PEDIATRIC INFORMATION

Welcome to our office! Please complete all questions. Thank you.

Our purpose is to educate and adjust as many families as is possible toward Optimal Health through natural Chiropractic care. Our job is to determine whether or not your health problems are the result of interference in your nerve system. The Chiropractic adjustment removes nerve interference and allows your body to heal from the inside-out.

HEALTHY BODY • HEALTHY SPINE • HEALTHY SOLUTION

Child's Name: _____ Address: _____

City: _____ Zip: _____

Home Phone #: _____ Birth Date: _____

Parent's Name: _____ Work Phone #: _____

Parent's E-mail Address: _____

How did you hear about our Health Center? _____

REGARDING YOUR CHILD

1. Were there any complications in your pregnancy or delivery? Y N _____
2. Was your child born by C-Section? Y N 3. Were forceps or other devices used? Y N
4. Did your child have early health challenges such as colic? Y N _____
5. Did/Does your child have ear infections frequently? Y N _____
6. Has your child had any spills or falls that concern you? Y N _____
7. Does your child complain of headaches, neck or back pain? Y N _____
8. Does your child have allergies or asthma? Y N _____
9. Does your child have a problem with bed wetting? Y N _____
10. Does your child have frequent temper tantrums? Y N _____
11. Are there any other health problems that concern you? Y N _____
12. When was the last time your child's posture was examined? _____
13. What medications, if any, is your child currently taking? _____
14. Was your child vaccinated? Y N _____
15. Was your child breast fed? Y N _____

Current Health Complaints/Reasons for Consulting Our Office:

1. _____ 2. _____

3. _____ 4. _____

Has your child had similar conditions in the past? Y N If so, when? _____

Financial Options:

The services provided in this office are rendered on a **CASH BASIS** only. Acceptable methods of payment include the following: (please circle your choice)

CASH CHECK MASTERCARD VISA

Payment plans are available upon agreement with the doctor after he/she determines whether or not to accept your case. Any insurance coverage will be validated at our office. All first visit charges are payable when services are rendered.

I understand and agree that insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand Mountainside Family Chiropractic Center will prepare any necessary reports and forms to assist me in making collections from the insurance company and that the insurance company will reimburse me directly. I understand that **I am personally responsible for payment**.

Child's Name: _____

Signature of Guardian: _____ Date: _____