

Welcome To Marion Family Chiropractic

Information for Minors

Today's Date: _____

Name: _____ Nick Name: _____ Date of Birth: _____ Age: _____

Address: _____
Street Town State Zip

Phone Number(s): _____ Social Security #: _____

Fathers Name: _____ Date of Birth: _____ Phone Number: _____

Address (if different from above): _____

Occupation: _____ Employer: _____

Mothers Name: _____ Date of Birth: _____ Phone Number: _____

Address (if different from above): _____

Occupation: _____ Employer: _____

Names & Ages of siblings: _____

Person accompanying minor today: _____ Relationship: _____

Reason for consulting this office:

- Wellness & Preventive care
- Specific pain and/or health problems (please explain)

Has this child/teen been under previous chiropractic care? ___Yes ___No If yes, when was the last visit? _____

Is there anything else significant happening in this child's/ teen's life that we should know about?

Authorization for care of minor (necessary if under 18):

I hereby authorize Marion Family Chiropractic to administer care as deemed necessary to my son/daughter/ ward:

Signed: _____ Date: _____ Relationship: _____

Person responsible for account: _____

Insurance Subscriber Name: _____ DOB ____/____/____

Complete Address _____ Sex ___M ___F

Demographic Data : Our Federal Office of Management and Budget (OMB) has asked that we collect the following Data. No personal information is associated with this data when we send it to OMB.

- Race:** American Indian or Alaskan Asian Black Caucasian Declined Other Race Pacific Islander
- Ethnicity:** Hispanic Non-Hispanic Declined
- Language:** Arabic Cantonese English French German Hindi Italian Japanese Korean Mandarin Other Persian Polish Portuguese Romanian Russian Spanish Tagalog Ukrainian Urdu Vietnamese

Has this child/ teen ever experienced any of the following? Please check off all that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Chronic Infections | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Colds/ Flu | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Difficulty in School |
| <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Inconsistent Sleep |
| <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Multiple Antibiotic Use | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Neck Problems | | |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Eats 3 meals per day |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Healthy Diet |
| <input type="checkbox"/> "Growing Pains" | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skips meals |
| <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Overeats |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Eats junk food |
| <input type="checkbox"/> Muscle Spams | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Drinks soda most days |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Constipation | <input type="checkbox"/> Eats too much sugar |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Stomach aches | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Bed Wetting | _____ |

Number of hours of sleep per night: _____ Quality of sleep: _____ Good _____ Fair _____ Poor

Has this child/teen ever had any reactions to immunizations? _____ If so, please describe: _____

Medication/Antibiotic History: _____

Current Medications: _____

Surgeries/ Hospitalizations: _____

Falls/Accidents/ Other Injuries: _____

Current Medical Doctor: _____ Other Health Care Providers: _____

Does this child/ teen participate in sports or physical activity? If so, What? _____

What does this child/ teen do after school? _____

Does this child/ teen volunteer or work? _____

What are their hobbies and interests? _____

How did you learn about this office? _____ Personal referral _____ Advertisement _____ Sign _____ Health Fair/Talk _____ Other

If you were referred, please note their name so we may personally thank them _____

Our mission is to improve the quality of your child's / teen's life through natural healing, to decrease or eliminate the need for drugs and medications, and to allow your child / teen to better express health and innate healing ability.

Welcome to our office.

Thank you. We look forward to providing your child's / teen's Chiropractic care.

Dr. Jennifer F. Eames
Dr. Belinda L. Marcil