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 #: _____

Parent 1Name: _____ Date of Birth:_____ Phone Number:_____

Address (if different from above): _____

Occupation:_____ Employer: _____

Parent 2 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:

□ Back Pain
□ Headaches
□ Orthopedic Problems
□ Joint Problems
□ Arm Problems
□ Leg Problems
□ Walking Problems
□ Neck Problems
□ Broken Bones
□ Arthritis
□ "Growing Pains"
□ Lyme Disease
□ Concussion
□ Paralysis
□ Muscle Spams
□ Convulsions
□ Fainting
□ Dizziness

□ Chronic Infections
□ Chronic Earaches
□ Colds/ Flu
□ Allergies
□ Asthma
□ Sinus Trouble
□ Multiple Antibiotic Use

□ Heart Problems
□ Hypertension
□ Diabetes
□ Hearing Problems
□ Vision Problems
□ Digestive Disorders
□ Diarrhea
□ Constipation
□ Stomach aches
□ Bed Wetting

□ Behavioral Problems
□ Hyperactivity
□ Anxiety
□ Depression
□ Difficulty in School
□ Inconsistent Sleep
□ Fatigue

□ Eats 3 meals per day
□ Healthy Diet
□ Skips meals
□ Overeats
□ Poor appetite
□ Eats junk food
□ Drinks soda most days
□ Eats too much sugar
□ Other: _____
_____

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. Allison Baker