

REGISTRATION INFORMATION

PATIENT INFORMATION

First Name: _____ MI: ___ Last Name: _____ Social Security: _____
Street Address: _____ City: _____ State: ___ Zip: _____
Sex: ___ M ___ F Date Of Birth: _____ Age: _____
Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed ___ Seperated
Employer Name and Address: _____
Home Phone: _____ Work Phone: _____
Cell: _____ E-Mail: _____
Emergency Contact Name: _____ Phone: _____
Who referred you to our office? _____

RESPONSIBLE PARTY INFORMATION

If you are the responsible party, mark "self" and move down to the "Insurance Information".

Patient's relationship to responsible party: ___ Self ___ Spouse ___ Dependent

First Name: _____ MI: ___ Last Name: _____ Social Security: _____
Street Address: _____ City: _____ State: ___ Zip: _____
Sex: ___ M ___ F Date Of Birth: _____ Age: _____
Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed ___ Seperated
Employer Name and Address: _____
Home Phone: _____ Work Phone: _____
Occupation: _____

INJURY INFORMATION

Is condition the result of an injury? ___ Yes ___ No If yes, **Work Related?** Y N **Auto Related?** Y N

INSURANCE INFORMATION

Insurance Company: _____ Phone Number: _____
Claims Address: _____
Group or Policy Number: _____ ID Number: _____
Secondary Insurance: _____ Phone Number: _____
Claims Address: _____

ASSIGNMENT AND RELEASE

I hereby assign, transfer and set over to Laux Chiropractic and Jonathan Laux, D.C. all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I revoke said authorization by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature: _____ Date: _____

Laux Chiropractic Pediatric History Form

Name: _____ Date: _____

Health History

Reason for contacting us? _____

How long has your child experienced this? _____

Is it getting better, same or worse over time? _____

Other health professionals consulted for this problem? _____

Other Health Problems? _____

Select any of the following that your child now experiences or has experienced in the past

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic Colds |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Colic | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Neck Pains | <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Back Pains | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | |
| <input type="checkbox"/> Attention Problems (ADD/ADHD) | <input type="checkbox"/> Bronchitis/Upper Respiratory Infections | | |

Are you content with your child's current level of health/wellness? Yes No If no, please explain: _____

Previous Chiropractic care? Yes No Reason for visits: _____

Has your child been treated by a physician for any reason in the past 12 months? Yes No
If yes, please explain: _____

Has your child taken any medication for an extended period of time in the past? Yes No
If yes, please explain: _____

Does your child take any herbal or vitamin supplements? Yes No
If yes, please explain: _____

Number of times your child has been on antibiotics: Past 6 months: _____ During their Lifetime: _____

Other medications your child has taken: Past 6 months: _____
During their lifetime: _____

Has your child received vaccinations? Y N

Does your child exercise? Y N What types? _____

Prenatal History

Name of Midwife or Obstetrician: _____ # Ultrasounds during pregnancy: _____

Any medications during pregnancy? _____

Any epidurals or medications during labor/delivery? _____

Was your labor induced? Yes No

Were any of the following used in delivery? Forceps Vacuum Extraction Other: _____

Any complications during delivery? Yes No If yes, please explain: _____

How long was your entire labor? _____ How long did you actually push? _____

Location of Birth: Hospital Birth Center Home

Birth Weight: _____ pounds Birth Length: _____ inches

Feeding History

Did you breast feed? Yes No If yes, how many months/years: _____

Formula fed? Yes No If yes, type? _____

Introduced solids at what age? _____ Cow's milk at what age? _____

Any food allergies/sensitivities? Yes No If yes, please list: _____

Developmental History

During the following times, your child's spine is most vulnerable to stress and should be routinely checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation.

At what age was your child able to :

Hold head up: _____ months Sit-Up: _____ months Crawl: _____ months Walk alone: _____ months

Trauma

Has your child ever fallen from a high place? (Bed, changing table, sofa, down stairs, etc) Yes No

If yes, please list: _____

Is your child involved in any sports? Yes No If yes, please list: _____

Has your child ever been involved in an auto accident as a passenger? Yes No If yes, please explain: _____

Has your child ever been to the emergency room? Yes No If yes, please explain: _____

Other traumas: _____

Any prior surgery? Yes No If yes, please list: _____

Childhood Illnesses

Please indicate if your child has experienced any of the following illnesses, and if so, at what age.

Chicken Pox: _____ Whooping Cough: _____ Mumps: _____

German Measles: _____ Measles: _____ Other: _____

Additional Comments: _____

Consent for Care

I understand that chiropractic care should not replace any other form of healthcare provided by other types of healthcare practitioners. I understand that my child is not being examined or treated for any conditions other than vertebral subluxation or the symptoms/conditions associated with vertebral subluxation.

Name of Child: _____

Signature of Parent/Legal Guardian: _____ Date: _____