FRYEBURG CHIROPRACTIC & WELLNESS CENTER

Name: _____ **Date of Birth:** _____ **Age:** _____

Mailing Address: _____

Parents Names: _____

Home Telephone: _____ **Emergency Contact Number:** _____

What is the reason for consulting our office at this time: _____

Cell/Text Number: _____

Text Carrier:

☐ Alltel	☐ Cingular	☐ Verizon
☐ ATT Wireless	☐ Sprint	☐ Virgin Mobile
☐ Boost	☐ T-Mobile	☐ Other
☐ Cellular One	☐ US Cellular	

ADOPTION INFORMATION

Child's Age When Adopted: _____ Date of Adoption: _____

Known Health History of Child: _____

_____

BIRTH INFORMATION

Birth Date: _____ Sex: ☐ Male ☐ Female Birth Weight: _____ Birth Length: _____ Current Age: _____

Type of Birth: ☐ Home ☐ Birthing Center ☐ Hospital ☐ Vaginal ☐ Forceps ☐ Breech ☐ Cesarean

Please describe any problems during pregnancy and/or labor: _____

_____

_____

Apgar Scores: _____ Jaundice(yellow) at birth? _____ Cyanosis(blue) at birth? _____

Congenital Anomalies/Defects: _____

Infant Feeding: ☐ Breast ☐ Bottle ☐ Formula Other Food/Drink Information: _____

_____

Average Hours of Sleep: _____ Quality of Sleep: ☐ Good ☐ Fair ☐ Poor Explain: _____

Number of Siblings _____ Sibling Names, Ages, Sex: _____

HEALTH AND MEDICAL INFORMATION

Obstetrician and/or Midwife: _____ Location: _____

Pediatrician and/or Family MD: _____ Location: _____

Date of Last Visit to Dr: _____ Purpose of that visit: _____

_____

Immunization History: _____

568 Main Street Fryeburg, ME 04037 phone: 207-935-3500 fax: 207-935-7384
www.fryeburgchiropractic.com

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Has your child ever been treated on an emergency basis? ☐ Yes ☐ No Please Describe: _____

Pregnancy History: _____

Delivery/Birth History: _____

Developmental History: At what age did the child…

_____ Respond to Sound
_____ Crawl
_____ Follow an Object with their Eyes
_____ Hold Head Up
_____ Stand
_____ Sit Alone
_____ Walk Alone

Childhood Diseases: Age of occurrence…

_____ Chicken Pox
_____ Rubella
_____ Rubeola
_____ Whooping Cough
_____ Mumps
_____ Measles
_____ Other(s): _____

Has the child ever suffered from (please check all that apply):

☐ Diabetes
☐ Fainting
☐ Dizziness
☐ Asthma
☐ Sugar concentration
☐ Sleeping problems
☐ Diarrhea
☐ Arm problems
☐ Arthritis
☐ Behavioral problems
☐ Bed Wetting
☐ Tuberculosis
☐ Stomach aches
☐ Walking problems
☐ Headaches
☐ Digestive disorders
☐ Constipation
☐ Hyperactivity
☐ Neuritis
☐ Muscle jerking
☐ Convulsions
☐ Backaches
☐ Allergies
☐ Rheumatic fever
☐ Blood disorders
☐ Sinus trouble
☐ Paralysis
☐ Chronic earaches
☐ Anemia
☐ Ruptures/Hernias
☐ Neck problems
☐ Heart trouble
☐ Orthopedic problems
☐ Hypertension
☐ Broken bones
☐ Leg problems
☐ Joint problems
☐ Colds/ Flu
☐ Poor appetite
☐ "Growing pains"
☐ Other Problems: _____

Present Health History or Additional Information: _____

Surgery History: _____

Medications: _____

Accidents: _____

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Family Health History: _____

AUTHORIZATION FOR CARE OF A MINOR

I HEREBY AUTHORIZE THIS CLINIC AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON ARRIVAL OF PARENT OR GUARDIAN).

PARENT/GUARDIAN SIGNATURE(S):

_____ **DATE:** _____

ACKNOWLEDGMENT

Name of person responsible for payment _____

Does person have insurance coverage? ☐Yes ☐No If yes, which company? _____

Subscriber:_____Subscriber DOB_____

(Name of person who carries insurance)

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. All charges are payable at the time of service unless, previous arrangements have been made. We will bill your insurance company; you will be responsible for any non-covered balance.

I hereby authorize Fryeburg Chiropractic and Wellness Center to furnish information to my insurance carriers concerning my child's diagnosis and treatment.

Signature:_____Date:_____

I acknowledge that I am aware of Fryeburg Chiropractic and Wellness Center's Privacy Notice. It is posted in the facility for me to read or I may request a paper copy of the Privacy Notice upon request to the Fryeburg Chiropractic and Wellness Center's Privacy Officer. Your signature is required to be compliant with HIPAA regulations.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine my child for further evaluation.

Name	SS#
Signature	Date
Parent/Guardian/Spouse Signature Authorizing Care	Date

This is to certify that Fryeburg Community Chiropractic has my permission to take X-rays. Initials _____

Female Patients: This is to certify that to the best of my knowledge I am NOT pregnant. Initials _____

Date of onset of last menstrual period _____

How did you hear about us? _____

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