Superior Family Chiropractic & Wellness

Patient Information – Please Print—Children Information

General Information

Patient Name ____
Address ______________________________ City ___________________ State ____ Zip ______
Phone __________________________Cell______________ Email _________________________

Date of Birth ________________Sex: M or F Married__ Single__ Divorced__ Widowed __
Social Security Number ______________________ Occupation____________________________
Employer ____ Phone ________________________
Full Time _____ Part Time_____ Retired _____ Not Employed _____ Student_____

Spouse's Name___________________________________ Their Employer ___________________

Referred by ________________________________

Release and Assignment

I authorize release of any information necessary to process my insurance claims and assign request payment directly to my physicians.

Patient Signature ____ Date ______________

CHILD INFORMATION ____________________________________

Please check health complaints your child is currently experiencing or experiencing on a recurring basis.

__ Asthma __ Headache __ Ear infection __ Colic __ Allergies

__ Bed wetting __ Other
____
____

Please check any childhood disease your child has had:

__ Chicken Pox __ Measles __ Mumps __ Rubella __ Whooping cough

__ Ear Infection __ Other
____
____

Please comment on how often any of the above diseases have occurred and when they occurred: ____ ___________
____

Pregnancy normal? __ Yes __No explain any complications ________________
____

Delivery: __ Home __ Hospital __Complications: ________________________
____

Medications during pregnancy/delivery ____________________________________
____

Immunizations: List those received and age at time _________________________
____

List any surgeries or congenital conditions: _________________________________
____
____

Reason for today's visit:____
____
____