Welcome to our office. Please complete this form to tell us how we can help you today.

firstchiropracticcenter.com

Patient Number _____
(office use only)

Today's Date: _____

Have you consulted a chiropractor before? ○ No ○ Yes

_____
Whom may we thank for referring you?

When? _____ If so, Whom? _____

First Name	MI	Last Name	Birthdate	Age	Gender ○M ○ F

Address	City	State	Zip

Primary Language	Race	Ethnicity	Preferred Communication
○ English ○ Spanish ○ Other	○ White ○ Hispanic ○ African American ○ Native American ○ Other	○ Hispanic or Latino ○ NOT Hispanic or Latino	○ Cell Phone ○ Home Phone ○ Work Phone ○ E-mail

Pediatrician	Father's Name	Mother's Name

Person Responsible for Account	Relationship to Patient

Cell Phone	Home Phone	Work Phone

E-mail Address	Employer of Parents

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I have read and reviewed the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **I may request a copy of the Financial Policy at any time.**

Initials ____ **I authorize my insurance company or administrator to pay First Chiropractic Centers, PC directly for the Benefits otherwise payable to me under my current policy**

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____ _____
Signature Date (MM/DD/YYYY)

On behalf of (print child's full name) _____

first chiropractic CENTERS P.C.

Patient Number _____
(office use only)

_____
Patient Name

What can the doctor help your child with today?

_____

PREGNANCY HISTORY

Duration of Pregnancy_____ Delivery at ☐ Home ☐ Hospital ☐ Other

Prenatal Healthcare: ☐ OB ☐ Supplements _____

☐ Medications_____ ☐ Complications _____

Prenatal Fitness _____

BIRTH HISTORY

Delivery ☐ Natural ☐ Drug-induced ☐ Drug-assisted ☐ C-section-Planned ☐ C-section-Emergency

Labor ☐ < 3 Hrs. (precipitous) ☐ 3-6 Hrs. ☐ 3-6 Hrs. ☐ 6-15 Hrs. ☐ > 15 Hrs. (prolonged)

Complications ☐ Abnormal Birth Position ☐ Forceps Used ☐ Spinal Anesthesia ☐ Vacuum Extractor

Baby Length and Weight at Birth _____APGAR Score_____

EARLY CHILDHOOD HISTORY
(age or duration)

Crying, Irritability_____Recurrent Ear Infections_____

Falls _____Nursing or Bottlefed_____

Medications_____Supplements_____

Surgery _____

RECENT HEALTH HISTORY

Falls _____Accidents _____

Surgery _____

Behavior At Home _____

School Performance _____

Eating Habits_____

Sleep Habits_____

_____
Doctor's Initials