

ABOUT THE PATIENT

Name _____ Today's Date _____ Birthdate _____ Age _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____ Gender M F
 Parents Names _____ Siblings Names and Ages _____
 School _____ Activities/ Hobbies/ Sports _____
 e-Mail Address _____ Have you been to a chiropractor before? No Yes
 Emergency Contact _____ ph # _____
 Name of Medical Doctor(s) _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Campbell Chiropractic to release and/or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: Cash Check Credit Card Car/Work Ins.

 Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

2. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

3. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

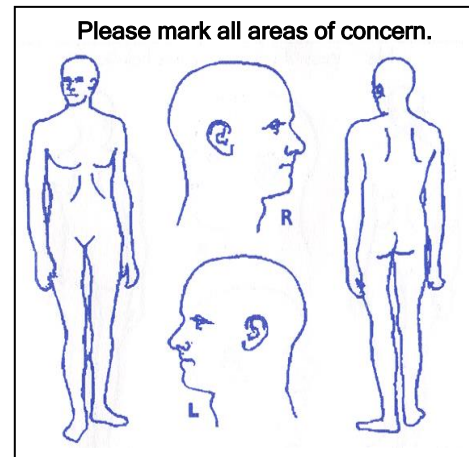
4. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

5. Does your condition affect: Sleep Work Daily Routine Sitting Driving

6. What makes it better? _____
 7. What makes it worse? _____
 8. What Doctor's have you seen for this? _____

 9. Type of treatment: _____
 10. Results: _____

NOTES: _____



GENERAL HEALTH HISTORY CHILD

Patient Name _____ *Mark the conditions that apply to you.*

Past	Present		Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping Problems	<input type="checkbox"/>	<input type="checkbox"/>	Difficult Latch
<input type="checkbox"/>	<input type="checkbox"/>	Colic	<input type="checkbox"/>	<input type="checkbox"/>	Growing Pains	<input type="checkbox"/>	<input type="checkbox"/>	Reflux
<input type="checkbox"/>	<input type="checkbox"/>	Allergies / Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Illness
<input type="checkbox"/>	<input type="checkbox"/>	Medication Side Effects	<input type="checkbox"/>	<input type="checkbox"/>	Temper Tantrums	<input type="checkbox"/>	<input type="checkbox"/>	Learning Difficulties
<input type="checkbox"/>	<input type="checkbox"/>	Recurring Fevers	<input type="checkbox"/>	<input type="checkbox"/>	ADHD/ADD	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Delay
<input type="checkbox"/>	<input type="checkbox"/>	Digestive problems	<input type="checkbox"/>	<input type="checkbox"/>	Seizures			
<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis			
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Colds/Sinus	<input type="checkbox"/>	<input type="checkbox"/>	Ever Needed Stitches			
<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Falls/Sports Accidents			
<input type="checkbox"/>	<input type="checkbox"/>	Other _____						

1. List any medications being taken: _____
2. Number of courses of Antibiotics child has taken in the last 6 mo. _____ Total during lifetime _____
3. Name of Pediatrician and Other Doctors: _____
4. Date of Last Visit ____/____/____ Reason: _____
5. Name of Obstetrician/Midwife: _____
6. Location of Birth: Hospital Birthing Center Home
7. Complications During Pregnancy: No Yes Explain: _____
8. Ultrasounds During Pregnancy: No Yes How Many: _____
9. Medication During Pregnancy / Delivery No Yes List: _____
10. Cigarette / Alcohol Use during Pregnancy: No Yes

PAST HISTORY

12. List any past auto collisions: _____ Was any care received? _____
13. List any past falls bumps bruises: _____ Was any care received? _____
14. List any past sport, recreational, or home injuries: _____
15. Please describe any past conditions and treatment received: _____

16. Please list any past hospitalizations and surgeries: _____

FAMILY HISTORY

- Father's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis Other _____
- Mother's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis Other _____
- Is there any other family history you want us to know? _____