ABOUT THE PATIENT

CAMPBELL CHIROPRACTIC
HEALTH. LIFE. FAMILY.

Campbell Chiropractic
6551 S Revere Pkwy, #110
»CentennialFamilyChiro.com

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____________________

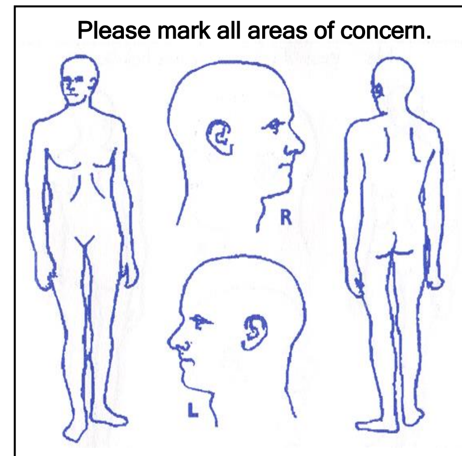
2. ______________________________ How long has this been an issue? _____
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to____________________

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: ______________________________
____
____

Please mark all areas of concern.



GENERAL HEALTH HISTORY CHILD

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Patient Name____ *Mark the conditions that apply to you.*

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

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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?____