Curis FUNCTIONAL HEALTH
COUNSELING • CHIROPRACTIC • NUTRITION

663 County Road 17, Suite 3
Elkhart, IN 46516

NEW PATIENT INTAKE FORM

Children 12 and younger

Please fill out the following pages completely and leave no questions unanswered. All of the information will give us the best representation of different stressors that you have accumulated through your life, whether it be physical, chemical or emotional. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.) _____ DOB: _____ Age: ____Today's Date: _____

Address (Street, City, State and Zip): _____

Cell Phone: _____SS#_____ Sex: ☐ M ☐ F

How did you hear about us? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Current Health Condition:

Chief Complaint (Why is the child here today?) _____

_____

Symptom's onset: _____

What may have caused the onset? _____

Since condition has begun, has anything helped? If yes, what? _____

_____

Is the child currently taking any prescriptions medications? ☐ YES ☐ NO If yes, please list name of drug, dosage and duration of use. _____

Review of Symptoms:

EARS, NOSE AND THROAT: ☐ Bleeding ☐ Discharge ☐ Dizziness ☐ Snoring ☐ Fainting
☐ Headaches ☐ Loss of smell ☐ Frequent sore throat ☐ Nasal congestion
☐ Sinus infections ☐ Ear drainage ☐ Ear infections ☐ Hearing loss ☐Ear pain
☐ Ringing in ears ☐ Post nasal drip ☐ Difficulty swallowing ☐ Hoarseness
☐Runny nose ☐TMJ Problems ☐NO SYMPTOMS

RESPIRATION: ☐ Asthma ☐Cough ☐Sputum production ☐ Coughing up blood ☐Wheezing
☐Shortness of breath ☐NO SYMPTOMS

GASTROINTESTINAL: ☐Abdominal pain ☐ Belching ☐Black tarry stool ☐ Constipation
☐Diarrhea ☐Difficulty swallowing ☐Heartburn ☐Hemorrhoids ☐Indigestion
☐Jaundice ☐Nausea ☐ Vomiting ☐Rectal bleeding ☐Abnormal stool consistency
☐Abnormal stool color ☐Abnormal stool quality ☐ NO SYMPTOMS

Health History:

Previous Chiropractic Care? ☐ Yes ☐ No If yes, who? _____

Has the child seen other doctors for this condition? ☐ Yes ☐ No If yes, who? _____

Birth Details: ☐ Uncomplicated vaginal birth ☐ Complicated vaginal birth ☐ C-Section

☐ Other/Other details not listed _____

Infancy Feeding Details: ☐ Breast Fed ☐ Formula Fed ☐ Combination of breast fed and formula

Has the child been admitted to the hospital since birth? ☐ Yes ☐ No If yes, please explain _____

_____

Has the child undergone any surgeries? ☐ Yes ☐ No If yes, please explain _____

_____

Has the child sustained any significant injuries since birth? ☐ Yes ☐ No If yes, please explain _____

_____

Has the child been immunized? ☐ Yes ☐ No If yes, please check all that apply. ☐ Flu ☐ Polio (IPV)

☐ Hepatitis A ☐ Hepatitis B ☐MMR (Measles, Mumps & Rubella) ☐Pneumococcal ☐Small Pox

☐ D-Tap ☐Chicken Pox ☐ Whooping Cough ☐ Other _____

Does the child have a history of antibiotic or prescription drug use? ☐ YES ☐ NO If yes, please list name of drug, dosage and duration of use. _____

Please add anything else you would like the doctor and/or staff to know about your child's past/present condition or anything regarding treatment. _____

_____

_____

Please mark all that apply.

FAMILY HISTORY ☐NONE	MOTHER	FATHER	SISTER	BROTHER	GRANDMOTHER	GRANDFATHER	CHILD
CANCER							
HEART							
DIABETES							
KIDNEY							
AUTOIMMUNE							
HEREDITARY							
PSYCHIATRIC							
OTHER							

Written Consent for a Child

Name of patient who is a minor/child _____

I authorize Dr. Derrick Hendricks and any and all Amberwood Terrace Chiropractic staff to perform diagnostic procedures, radiographic evaluations, renders chiropractic care and perform chiropractic adjustments to my minor/child.

As of this date, I have the legal right to select and authorize healthcare services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Amberwood Terrace Chiropractic.

Guardian Signature _____ Date:_____

Witness Signature:_____Date: _____