

Child's Welcome Form

Today's Date: _____

NAME: _____

AGE: _____ Sex: Male / Female

Address:

Phone: _____

Social Security Number:

Date of Birth: _____

Referred By: _____

Reason for Visit Today:

When did this problem first occur?

Y/ N- Have you had this problem before?

Y/ N- Have you previously been treated for this problem? If yes, Doctor's Name:

Y/ N- Have you previously been to a chiropractor? If so, when:

Doctor's Name: _____

ABOUT YOUR HEALTH:

Please circle Y (yes) or N (no)

In the past year have you had any of the following

Y / N- Back or neck pain?

Y / N- Pains in the legs or arms?

Y / N- Headaches?

Y / N- Asthma?

Y / N- Allergies?

Y / N- Earaches?

Y / N- Falls from a bicycle, skateboard, scooter, rollerblades or similar?

Y / N- Do you ever have a problem with bedwetting?

Y / N- Have you ever been in a motor vehicle accident?

Y / N- Have you ever had any broken bones? If yes, please give date:

Y / N- Have you ever had any surgeries? If yes, please give date:

Y / N- Are you at present taking any medications? If yes, please list:

Y / N- Do you have any other health problems?

ABOUT YOUR LIFESTYLE

What grade are you in at school?

How do you carry your schoolbooks?

What sports do you play?

Child's Welcome Form

How many hours each day do you watch T.V? _____

How many hours each day do you spend on the computer? _____

How often do you play video games? _____

On average, how many hours sleep do you get each night? _____

Are there any smokers in your family? _____

Do you feel stressed out? Y / N

Do you have trouble reading the black board in class? Y / N

Do you wear glasses or contact lenses? Y / N

Do you sometimes get headaches when you read? Y / N

ABOUT YOUR DIET

What do you usually eat for Breakfast? _____

What do you usually eat for Lunch? _____

What do you usually eat for Dinner? _____

What snacks do you have after school? _____

What is your favorite food? _____

How much water do you drink each day? _____

How many sodas or colas do you drink each day? _____

How often do you eat fast food items? _____

ARE THERE ANY OTHER HEALTH CONCERNS THAT YOU WOULD LIKE THE DOCTOR TO KNOW ABOUT?

CONSENT TO TREATMENT OF A MINOR CHILD

I hereby authorize Dr. Corsello and whomever he may designate as assistants to administer care as deemed necessary to my _____ (indicate relationship to child),

(Name of Child)

Guardian's Name: _____

Guardian's Signature: _____

Date: _____