

# Lifestyle Chiropractic

821 Sibley Memorial Highway, Mendota Heights, MN 55118  
651-406-4454

www.LifestyleChiroCenter.com

Progressive Chiropractic - Massage - Spinal Decompression - Nutrition - Exercise

Welcome to our office! Please complete all questions completely and accurately!

## ABOUT THE CHILD

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Birth date \_\_\_\_\_

Age \_\_\_\_\_ Gender \_\_\_\_\_ Weight \_\_\_\_\_

## ABOUT THE PARENT

Name \_\_\_\_\_

Employer \_\_\_\_\_

Work address \_\_\_\_\_

Work phone \_\_\_\_\_

Type of work \_\_\_\_\_

Marital Status \_\_\_\_\_

Social Security # \_\_\_\_\_

Driver's License # \_\_\_\_\_

E-mail address \_\_\_\_\_

Payment Method for First Visit  Cash  Check  Credit card

## REASON FOR THIS VISIT

Current Health Complaints/Reasons for consulting our office.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Is the purpose of this appointment related to

Sports  Auto  Fall  Home Injury

Chronic Discomfort  Other

Please explain \_\_\_\_\_

When did this condition begin? \_\_\_\_\_

Has this condition

gotten worse  stayed constant  comes and goes

Does this condition interfere with

Sleep  Daily routine  other activities

Please explain \_\_\_\_\_

Has this condition occurred before?  Yes  No

Please explain \_\_\_\_\_

Have you seen other doctors for this condition?

Yes  No

Doctor's Name(s) \_\_\_\_\_

Type of treatment \_\_\_\_\_

Results \_\_\_\_\_

## AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that

Yes No

• Doctors of Chiropractic work with the nervous system?

• The nervous system controls all bodily functions and systems?

• Chiropractic is the largest natural healing profession in the world?

• If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?

## VACCINATIONS

Have you chosen to vaccinate your child?  Yes  No

If yes, check all that your child has received.

DPT  MMR  Chicken Pox  Hepatitis  Other

Describe any and all reactions to vaccine(s).

\_\_\_\_\_

## EXPERIENCE WITH CHIROPRACTIC

Who can we thank for referring you to this office? \_\_\_\_\_

Have you personally been adjusted by a Chiropractor before?  Yes  No \_\_\_\_\_

Reason for those visits? \_\_\_\_\_

Doctor's name \_\_\_\_\_ Approximate date of last visit \_\_\_\_\_

Has your child been adjusted by a Chiropractor?  Yes  No Approximate date of last visit \_\_\_\_\_

Has any adult in your family seen a Chiropractor?  Yes  No

## CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- |   |   |   |  |   |
|---|---|---|--|---|
| <input type="checkbox"/> Allergies          | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Bed wetting        | <input type="checkbox"/> Irritability  | <input type="checkbox"/> Constipation       |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Headaches      | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Colic              |
| <input type="checkbox"/> Attention problems | <input type="checkbox"/> Hyperactivity  | <input type="checkbox"/> Sleeping Problems  | <input type="checkbox"/> Tubes in ears | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Vision Problems    | <input type="checkbox"/> Ear Problems   |   |  |   |
| <input type="checkbox"/> Other _____        |   |   |  |   |

## CHILD'S CURRENT HEALTH STATUS

	No	Yes	If Yes, please explain
Has your child ever:			
...taken antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...had a severe fall?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...been in a car accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is your child			
...accident prone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...currently taking any medication(s)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...having difficulty interacting with others?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?			_____
What changes (if any) in your child's health or behavior would you like accomplished?			_____

## AUTHORIZATION TO CARE FOR A MINOR CHILD

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desire for your child(ren) when recommending his/her treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief care** – Symptomatic relief of pain or discomfort
- Corrective care** – Correcting and relieving the cause of the problem as well as the symptoms
- Comprehensive care** – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care
- I want the Doctor to select the type of care appropriate for my child, and for the doctor to examine and/or treat my child.

\_\_\_\_\_  
Parent or legal guardian's name (print)

\_\_\_\_\_  
Patient's name (print)

\_\_\_\_\_  
Parent/Guardian's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness' signature