The Back & Neck Pain Center of Monterey

1299 Pacific Street * Monterey, CA * 93940
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# NEW PATIENT (CHILD) INTAKE FORM

## PATIENT INFORMATION

Patient Name (First, MI, Last): _____Today's date: _____

Parent's Name (Mother) _____ (Father) _____

Address: _____City:_____ State:_____ Zip: _____

Phone (Mother Cell):_____ Phone (Father Cell):_____

Parent Email Address:_____

Patient Date of birth:____/____/____ Age:_____ ▢ Male ▢ Female

Emergency Contact: _____ Relation: _____ Phone:_____

How did you hear about our office? ▢ Website ▢ Yelp Other:_____

Whom may we thank for referring you?_____

Do you have health insurance? ▢ Yes ▢ No Insurance company name: _____

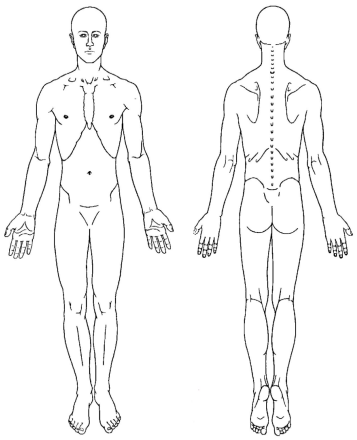
(Have you already given the staff your insurance information if you are interested in using insurance?)

## PATIENT CONDITION

The symptoms that prompted you to seek care today include:_____

And are a Result of? ☐ Fall ☐ Car Accident ☐ Sports/ Activity ☐ Birth

☐ Unknown ☐ Other: _____



Location (where does it hurt? Mark on Body with an X)

Radiating (does the pain travel to other parts of the body?)

☐ Head ☐ Neck ☐ Arms ☐ Legs ☐ Feet

Aggravating/ Relieving (Time of day or activities)

What makes it worse? _____

What makes it better? _____

Choose the level of Discomfort (Circle) **0 1 2 3 4 5 6 7 8 9 10**

When did they start feeling this pain?: _____

How often does your child feel this pain? ☐ Constant ☐ Only once ☐ Comes and goes ☐ Other:_____

Prior Interventions (what have you done for relief?) ☐ OTC Meds ☐ Prescription Meds ☐ Heat ☐ Ice

☐ Chiropractic ☐ Other: _____

Name of any other health care provider you have sought help from for this problem?_____

## HEALTH HISTORY

**HAS YOUR CHILD EVER HAD OR DO THEY CURRENTLY HAVE ANY OF THESE SYMPTOMS?**

| | | | |
|---|---|---|---|
| ☐ Allergies | ☐ Bed Wetting | ☐ Headaches | ☐ Scoliosis |
| ☐ Appetite Issues | ☐ Colic/ Constipation | ☐ Hyperactivity | ☐ Fractures |
| ☐ Asthma | ☐ Ear Infections | ☐ Leg Cramps | ☐ Disclocations |

Allergies_____

Other _____

What are your child's regular sleeping habits? ☐ 0-4 hrs/night ☐ 4-8 hrs/night ☐ 8+ hrs/night

How does this current condition interfere with:

Sleep Patterns:_____

Mobility- crawl / walk / stand:_____

Speech Pattern:_____

Behavior Issues:_____

## AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this clinic and it's doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian)

Print name:_____Relation:_____

Signature:_____Date:_____

## X-RAY CONSENT - sign only if needed after meeting and discussing with Dr.

The doctor has explained that the purpose of X-rays is to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing this X-ray, I will be informed. I then must determine if I should seek the service of an additional health care provider for advice, diagnosis, or treatment for the unusual finding. I understand that seeking advice from another type of health care provider should not interfere with the subluxation correction care provided by this office.

I fully understand the above and consent to chiropractic spinal X-rays.

Parent's signature:_____Date:_____