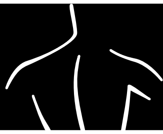

Palmer Chiropractic

Date ______________________________ Case No.______________________

Name _________________________________ Address ____

Phone _____________________________ Date of Birth ______________________ Age ______________ Male/Female

Parent or Guardian's Name ____

Parent or Guardian's Social Security # ____

Address (if different from child's) ____

Chief complaint or problem ____

What type of birth:

_____ Vaginal _____ C-Section _____ Forceps _____ Suction Cup

Presentation: _____ Normal _____ Breach _____ Frontal

With anesthesia (pain killer)? _____ Yes _____ No

Type used: _____ Oral _____ Hypo _____ Spinal Block _____ Subdural Injection _____ General Anesthesia

Child Presently Has _____X or Has Had _____ ✓

_____ Cholic _____ Chicken Pox _____ Measles _____ Mumps Right/Left _____ Colds

_____ Constipation _____ Diarrhea _____ Difficult Sleeping _____ Overactive _____ Asthma

_____ Difficult Breathing _____ Skin Eruptions _____ Vomiting _____ Frequent Crying

_____ Feet Turn Out Right Left Both _____ Feet Turn In Right Left Both

Falls: (details) ____

____

___

Injuries: (details) ____

____

___

Is she/he taking any medication? Prescription or patent? ____

If so, what drugs? ____

Operations: _____ Ear Tubes _____ Tonsillectomy _____ Heart Other _________________________________

I hereby authorize Dr. Palmer and/or whomever he may designate as his assistant to administer Chiropractic care as he deems necessary to my child. It is understood and agreed the amount paid to Palmer Chiropractic Center for X-Ray is for examination only, and the X-Ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. I understand that if my insurance company covers services and the check(s) is sent to the patient, it is the patients responsibility to bring the check and explanation of benefits to this office. I understand and agree that if my insurance or medicare fails to provide payment for services rendered that it is my responsibility to pay for these services. Co-pays and/or deductibles that are left unpaid for more than 30 days will incur an 18% interest rate, per month of deliquency.

_________________________________ _________________________________

Parent/Guardian Name (Print) Parent/Guardian Signature