Welcome To Our Office!

Date:_____

Child's First Name _____Middle Initial_____Last Name_____

Address:_____

City:_____State:_____Zip Code:_____

Home Phone:_____Cell Phone:_____

DOB: _____ Age: _____Email:_____

Parents/Guardians :_____

Pediatrician:_____Phone Number:_____

Who may we thank for referring you to us?_____

1. What is the main concern for today's visit?

_____

_____

2. If pain, please describe and give location: _____

_____

3. How often are the symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How are the symptoms changing with time?

□ Getting Worse □ Not Changing □ Getting Better

5. Using a scale from 0-10 (10 being the worst), how would you rate the problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

6. Other Doctors seen? _____

7. When did this problem begin? _____

8. How do *you* think it started? _____

Name_____

9. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

10. What makes it worse?
_____

11. What makes it better?
_____

12. What concerns you the most?
_____

13. Child's Height_____ Weight _____ Date of Birth _____

14. How would you rate your child's overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

15. Family Medical Conditions or History_____

Medical History:

Check any of the following conditions your child has suffered from during the past six months:

□ Difficult Breastfeeding □ Ear Infections □ Seizures □ Chronic Colds □ Headaches □ ADHD/ADD
□ Digestive Problems □ Asthma/Allergies □ Colic □ Growing / Back Pains □ Recurring Fever
□ Temper Tantrums □ Bed Wetting □ Scoliosis □ Difficulty Sleeping
□ Other Medical conditions:
_____

Vaccination History: _____

Antibiotics or other Medication history: _____ In the last six months: _____

Prenatal History:
Name of Obstetrician/Midwife: _____Location of Birth:_____
Birth Weight: _____Birth Length: _____ APGAR Scores: _____

Complications during pregnancy? □ Yes □ No If Yes, what: _____
Cigarette/Alcohol during pregnancy? □ Yes □ No If Yes, what: _____
Medication during pregnancy/delivery? □Yes □ No If Yes, what:_____

Birth Interventions: □ Forceps □ Vacuum Extraction □ Cesarian Section (□ Emergency □Planned)
Complications during delivery? □ Yes □ No If Yes, what: _____
Genetic disorders or disabilities? □ Yes □ No If Yes, what: _____

Feeding History
Breast fed: □ Yes □ No How long: _____ Formula fed: □ Yes □ No How long: _____
Introduction to: solids at: _____ months Cows' milk at _____ months
Food / Juice allergies or intolerances: □ Yes □ No If Yes, what: _____

Name_____

Developmental History:
At how many months was your child able to: _____ Respond to sound _____ Respond to visual stimuli
_____ Hold head up _____ Sit up _____Cross crawl _____ Stand alone _____ Walk alone

16. List all current medications:

_____

17. List all current vitamins/supplements:

_____

18. Is your child involved in sports? □ No □ Yes What type:_____

19. List any surgical procedure or hospitalizations:

_____

20. Has your child ever been treated by a chiropractor? □ No □ Yes
If so, explain when/why: _____
Did they take x-rays?_____

21. Have your child had significant past trauma? □ No □ Yes _____

_____

22. Anything else pertinent to your visit today? _____

CONSENT TO TREAT: I hereby request and consent to the performance of chiropractic treatment, including various modes of adjunctive therapy by Dr. Abigail Perri. This consent is extended to other chiropractors or chiropractic assistants, who now or in the future, are employed by, working with, or associated with this office. I understand that there are some risks to treatment and I will rely on the doctor to exercise appropriate judgment during the course of care, based on the facts known at this time, and in my best interest.

Signature_____ Date_____

CONSENT TO TREAT A MINOR CHILD: I hereby authorize Tree of Life Wellness to administer chiropractic treatment as deemed necessary for my child.

Print Name_____ (Parent/Legal Guardian)

Signature_____ (Parent/Legal Guardian) Date_____

FINANCIAL/INSURANCE POLICY: I understand and agree that health and automobile insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Tree of Life Wellness will submit claims to my health insurance as an out-of-network/non-participating provider to assist me in making collection from the insurance company. Any amount authorized to be paid directly to Tree of Life Wellness will be credited to my account upon receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I further agree that if my account is referred to a collection agency and/or attorney, I agree to pay the collection agency fees, attorney's fees, and court costs associated with the collection process.

Signature_____ Date_____