



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 Cesarean 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 Oleston Chiropractic, PA 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 Oleston Chiropractic, PA 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 Oleston Chiropractic, PA 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 _____