

# TENOLD CHIROPRACTIC HEALTH & REHAB CLINIC

[www.tenoldchiropractic.com](http://www.tenoldchiropractic.com)

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## NEW PATIENT INFORMATION – MINOR – 6 THROUGH 17 YEARS OLD

### About you...

Name: First: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last: \_\_\_\_\_ Date: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone (     ) \_\_\_\_\_ Name of School \_\_\_\_\_  
DOB:     /     /     Age:     Male/Female     Student Status: full time/part time/not enrolled

### Parent or Guardian information...

Father: \_\_\_\_\_ Mother: \_\_\_\_\_  
SS# \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_ DOB: \_\_\_\_\_  
 Check box if same address as patient      Check box if same address as patient  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Home/work phone \_\_\_\_\_ Home/work phone \_\_\_\_\_  
Employer \_\_\_\_\_ Employer \_\_\_\_\_  
Legal Guardian: yes / no \_\_\_\_\_ Legal Guardian: yes / no \_\_\_\_\_

### Billing Information... (This is the person to whom the statements are sent.)

Person responsible for the account: \_\_\_\_\_  
If different from patient's, what is their: 1.) address: \_\_\_\_\_  
2.) Phone: (     ) \_\_\_\_\_  
Insurance company: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Auto accident Y / N     School injury Y / N     Work injury Y / N  
Has your child had chiropractic care before? Y / N     If so, when? \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_ Email address: \_\_\_\_\_

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**About your health...**

In order of importance, what conditions are you most interested in correcting?

1.)

2.)

3.)

In order of severity, what functions are you unable to perform, i.e. sitting, bending, etc.?

1.)

2.)

3.)

What activities make your condition worse?

Is your condition: getting worse / getting better / staying the same / constant / comes and goes

Is your condition interfering with: work / daily routine / sleep / other?

How long have you been in pain?

Have you been in an auto accident: Past twelve months? yes/no; One to five years ago? yes/no;  
Over five years? yes/no; Never

Have you ever had a personal injury or accident? Past twelve months? yes/no;  
One to five years ago? yes/no; Over five years? yes/no; Never

Have you ever had any mental or emotional disorders? yes / no When?

Have others in your family had such disorders: yes / no When?

Are you wearing: Heel lift yes / no Insoles yes / no Arch supports yes / no

Do you take vitamins or minerals? yes / no Please list.

Do you have an allergy to any drug? yes / no Please describe.

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**Current medication(s)...** *List all medications that you are currently taking. Also note the reason you were prescribed the medication.*

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**Past Medical History...** *Please include date and type.*

Surgeries:

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Fractures:

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Breast implants, hip replacement, knee replacement or other surgical implants? Yes / No

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Serious illnesses:

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Date of last:	Spinal exam	Spinal X-ray	Urine test	Blood test
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Circle any of the conditions you have had in the past or are currently experiencing:

- |                  |                |                    |                  |
|------------------|----------------|--------------------|------------------|
| AIDS             | Diphtheria     | Influenza          | Rheumatic fever  |
| Alcoholism       | Eczema         | Malaria            | Scarlet fever    |
| Anemia           | Emphysema      | Measles            | Stroke           |
| Appendicitis     | Epilepsy       | Miscarriage        | Tuberculosis     |
| Arteriosclerosis | Fever blisters | Multiple sclerosis | Typhoid fever    |
| Arthritis        | Goiter         | Mumps              | Ulcers           |
| Cancer           | Gout           | Pleurisy           | Venereal Disease |
| Asthma           | Heart disease  | Pneumonia          | Whooping cough   |
| Cold sores       | Hepatitis      | Polio              | Lyme's Disease   |
| Diabetes         | HIV            | Allergies          |                  |

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**Habits...**

Please circle that which is appropriate.

- Alcohol: ..... \_\_\_\_\_ per day / week / month  
Coffee, tea (decaf or reg) ..... \_\_\_\_\_ per day / week / month  
Soda (reg / diet / decaf) ..... \_\_\_\_\_ per day / week / month  
Tobacco (smoke / smokeless) ..... \_\_\_\_\_ per day / week / month  
Drugs – recreational ..... \_\_\_\_\_ per day / week / month  
Exercise ..... \_\_\_\_\_ hours per day / week  
Sleep ..... \_\_\_\_\_ hours per night  
Water intake..... \_\_\_\_\_ glasses per day

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**Family Physician/Pediatrician...**

Name: \_\_\_\_\_

Clinic Name/Location: \_\_\_\_\_

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**Mark the appropriate sensation...** *Numbness >>> Pins & Needles ooo Burning xxx Stabbing /// Aching (((*



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**CONSENT FOR TREATMENT OF A MINOR CHILD**

I hereby authorize the doctors at Tenold Chiropractic Health Clinic and whomever they designate as their assistant to administer chiropractic care as they deem necessary to my son / daughter (circle one).

Name of Child: \_\_\_\_\_

Dated at Eau Claire, WI on: \_\_\_\_\_

Parent or Legal Guardian signature: \_\_\_\_\_

Witness: \_\_\_\_\_

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I authorize the release of any medical or other information necessary to process this claim. I understand and agree that any amount authorized to be paid directly to Tenold Chiropractic will be credited to my account upon receipt. I clearly understand that if I suspend or terminated my care and treatment, any fee for professional services rendered me will be immediately due and payable. I further understand that in the event that my responsible party, insurance co., etc. does not cover the full amount, I will pay the balance of my account in full.

I understand that I am accepted as a patient of Tenold Chiropractic. I am authorizing them to proceed with any further treatment that may be necessary. Furthermore, any risks involving chiropractic treatment will be explained to me upon request.

Parent/Guardian authorizing care: \_\_\_\_\_ Date \_\_\_\_\_

*Revised 01/20/2006*

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