



KidsChiroCare

www.KidsChiro.com

Confidential Patient Information

Please fill in as completely as possible.

Thank you!

First Name:		M.I.	Last Name:		Age:
Street Address:			City:		Zip Code:
Home Phone:		Second Phone:		Parent E-mail:	
Parent First Name:		Last Name:		Parent SSN:	
Person responsible for account (if different from above)		Relation	Address		SSN
Sex:	Birth date:	Method of Delivery: Vaginal C-section		Is child being vaccinated? Yes No	Was child breastfed? Yes No How long?
Pregnancy: Normal Complicated		Labor: <input type="checkbox"/> Natural Induced How long? _____		Delivery: Natural Medicated	APGAR score: _____

History	Medical complications, accidents, injuries or health problems:
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About the Problem	Health Problem or Purpose for Visit:	
	Do you know the cause of problem?	
	Date symptoms appeared?	Are they: Improving? Getting Worse? Same? Come & Go?
	What has been done for this condition?	
	What makes it better?	<div style="display: flex; align-items: center;"> <div style="writing-mode: vertical-rl; transform: rotate(180deg); font-weight: bold; margin-right: 5px;">↓ Mark areas of symptoms ↓</div> </div>
	What makes it worse?	
	Other Health Problems or Conditions or Comments:	

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to Dr. Peters with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I hereby consent to treatment of my minor child by Dr. Gary Peters, DC

Parent Signature

Date