Northern Lights Chiropractic Children's Information Form

Name:			Parent/Guardian:
Birth Date:	Age:		
Address:			
City	State:	Zip:	Home phone:

- Favorite Hobbies or Interests _____
- Reason for consulting this office_____
- Has this child ever been to a chiropractor before? Yes No If so, where and how often?

_____

Please answer the following to help us determine any stresses affecting the child's nervous system.

- Is the child currently taking any drugs? (prescription or over the counter) If yes, what and for how long?

_____

- Has the child been vaccinated? Yes or No

- Has the child ever had any falls, auto collisions or injuries? If yes please describe.

_____

_____

- Has the child ever been hospitalized or had any surgeries? If yes please describe.

_____

- Was there any type of birth trauma? (C-section, Forceps, vacuum extraction etc.) If yes please describe.

_____

- Please circle your child's level of physical activity: Low Moderate High

- Is there a particularly stressful area in the child's life? (home, school, relationships, loss of loved ones, etc…)

_____

_____

I authorize my insurance company to pay to this office all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the release of all information necessary to secure the payment of benefits, as outlined in this office's privacy policies.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Parent or Guardian Signature:_____Date:_____

Payment is due in full at time of treatment unless prior arrangements have been made.