

NEW PATIENT INFORMATION

Name _____ SS# _____

Address _____ City _____ State _____ Zip _____

Birth date _____ Age _____ Male _____ Female _____ Marital status _____

By giving the following phone numbers I authorize the use of calls/voicemails

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Occupation _____

Employer _____ Phone _____

Give us your e-mail If you want e-mail appointment reminders and our monthly newsletter

E-mail address _____

PARENT OR SPOUSE INFORMATION

Name _____ SS# _____

Employer _____

How did you find us? Referred by _____ medical doctor, friend, family
 Phone book which? *Yellow book, Dex, Pdc,* Website, Internet, Street Sign Mailer
 Other _____

NEW OR UPDATED AUTHORIZATION FOR TELEPHONE CALLS AND OFFICE MAIL

Federal HIPAA laws allow you to restrict or change the means for the doctor and staff to communication with you or to contact you through alternative means. In order for our office to keep current with changes in addresses or telephone numbers or simply preference choices, we need your permission to contact you via telephone at your work or home, cellular telephone, pager, email, or to leave messages on your answering machine. Your agreement will allow our office to use your name and mailing address for sending reminders about scheduled appointments, re-activation letters, sending birthday/holiday cards, office newsletters, or providing information about other health related matters that may be of interest to you, billing statements/questions, status of your account, and other office related matters. **If you have a telephone number that you do not want used for messages or calls, please do not write these numbers on your intake forms.** You may indicate a new or preferred mailing address by indicating so on this form. This authorization may be revoked by you, at any time, by advising our office (privacy officer) of this revocation in writing. If you choose not to sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment, or payment.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PROVIDE MY CURRENT INSURANCE INFORMATION

Signature _____ **Date** _____ **No expiration date**

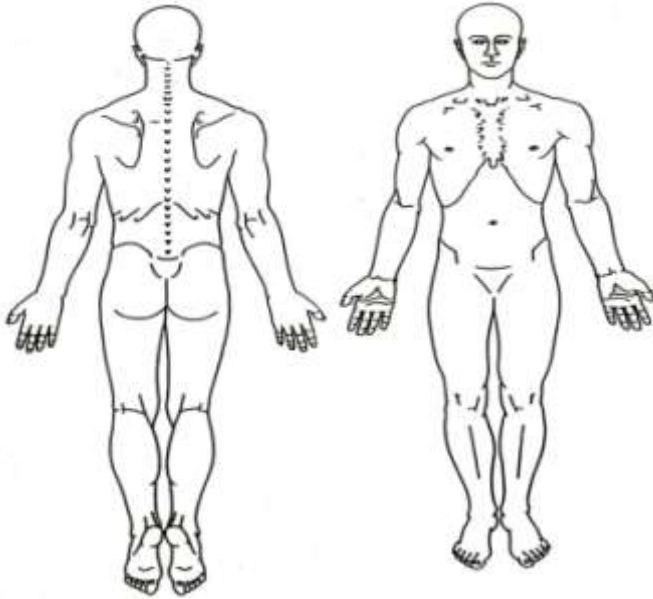
Expiration Date/Event for Authorization: Date: _____ Expires When treatment/billing has concluded with our office

Child's Name: _____ Date: _____

Age: _____ Grade in school: _____ Name of school: _____

1. Describe the

main complaint and mark the areas of complaint on the body drawing:



2. How long has the complaint been present? _____

3. What do you think caused the complaint? _____

4. Was there a fall or injury prior to the onset of pain? No Yes, if yes describe what happened _____

5. Has child had PRIOR similar complaints? No Yes, if yes describe _____

6. Is the pain:

- Constant Nearly constant
- Frequent Comes and goes

7. Are the symptoms worse: After play While playing
 At night before going to sleep Child wakes up at night in pain
 Random times
 Other _____

8. What makes the pain better: Rest Medication

Other _____

9 Has the condition been diagnosed by another health care professional?

No Yes, if yes: _____

10 Is the child under a pediatrician's care for any condition?

No Yes, if yes: _____

11 When was the last pediatric check up? _____

12 Is the child taking any prescription or over the counter medications?

No Yes, if yes: _____

13 Has the child been told during scoliosis screening that scoliosis was present or questionable? No Yes

14 Do any blood relatives have scoliosis? No Yes

15 Has the child been in an auto accident No Yes, when? _____

Was the child treated for any injuries? _____

Did your child completely recover from those injuries? No Yes

16 Describe past injuries or falls: _____

17 Has child had surgery? No Yes if yes explain, _____

18 Is child involved in sports? No Yes _____

19 Childhood history: what childhood diseases and/or other problems has the child had?

Chicken pox Measles Whooping cough Mumps

Repeated ear infections/buttons? No Yes

Repeated coughs Weight loss Bed wetting

Learning problems Allergies Repeated colds

Other

20 Birth history: Was the pregnancy full term? No Yes

Were there any complications with the birth? No Yes

21 Please note anything else you want the doctor to be aware of: _____

Parent's signature: _____ Date: _____

Doctor reviewed history with patient's parent or guardian