WOODLAKE CHIROPRACTIC

Dr. Paul Zilka
Dr. Ann Zilka

About the Child

Name _____

Today's date _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Birth date _____

Age _____ Gender _____ Weight _____

About the Parent

Name _____

Employer _____

Work address _____

Work phone _____ Cell _____

Marital status _____

Social Security # _____

Email address _____

Payment method for first visit: ☐ Cash ☐ Check ☐ Credit Card

Reason for this Visit

Current health complaints/reasons for consulting our office:

1. _____
2. _____
3. _____
4. _____

Is the purpose of this appointment related to:

☐ Sports ☐ Auto ☐ Fall ☐ Home injury
☐ Chronic discomfort ☐ Other

Please explain _____

When did this condition begin? _____

Has this condition:

☐ Gotten worse ☐ Stayed constant ☐ Comes and goes

Does this condition interfere with:

☐ Sleep ☐ Daily routine ☐ Other activities

Please explain _____

Has this condition occurred before? ☐ Yes ☐ No

Please explain _____

Have you seen other doctors for this condition? ☐ Yes ☐ No

Doctor's Name(s) _____

Type of treatment _____

Results _____

Vaccinations

Have you chosen to vaccinate your child? ☐ Yes ☐ No

If yes, check all that your child has received:

☐ DPT ☐ MMR ☐ Chicken Pox ☐ Hepatitis ☐ Other

Describe any and all reactions to vaccine(s):

_____

Awareness of Chiropractic Principles

Were you aware that	Yes	No
Doctors of Chiropractic work with the nervous system?	☐	☐
The nervous system controls all bodily functions and systems?	☐	☐
Chiropractic is the largest natural healing profession in the world?	☐	☐
If Chiropractic care starts at birth you can achieve a higher level of health throughout life?	☐	☐

Experience with Chiropractic

Who can we thank for referring you to this office? _____

Have you personally been adjusted by a Chiropractor before? ☐ Yes ☐ No Reason for those visits _____

Doctor's Name _____ Approximate date of last visit _____

Has your child been adjusted by a Chiropractor? ☐ Yes ☐ No Approximate date of last visit _____

Have any other family members seen a Chiropractor? ☐ Yes ☐ No

phone 612.866.9194 fax 612.866.9963 web www.woodlakechiro.com email woodlakechiro@yahoo.com

Mother's Pregnancy & Labor

During Pregnancy:

☐ Drugs / Medicine ☐ Tobacco / Alcohol

Please explain _____

Any illness during your pregnancy? _____

_____

How was your delivery? _____

☐ Labor chemically induced ☐ Labor was Dr. assisted

☐ C-section delivery ☐ Forceps / vacuum extraction?

☐ Did Dr. pull or twist baby? ☐ Premature delivery

Please explain _____

Did you nurse the baby? ☐ Yes ☐ No

Did your baby have colic? ☐ Yes ☐ No

Feeding problems? ☐ Yes ☐ No

Child's Health History

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

☐ Allergies
☐ Asthma
☐ Attention problems
☐ Bed wetting
☐ Breathing problems
☐ Colic
☐ Constipation
☐ Digestive problems
☐ Ear problems
☐ Frequent colds
☐ Headaches
☐ Hyperactivity
☐ Irritability
☐ Skin problems
☐ Sleeping disorders
☐ Tubes in the ears
☐ Vision problems
☐ Other _____

Child's Current Health Status

Has your child ever:	Yes	No	If yes, please explain
...taken antibiotics?	☐	☐	_____
...been hospitalized?	☐	☐	_____
...had a severe fall?	☐	☐	_____
...been in a car accident?	☐	☐	_____
Is your child:			
...accident prone?	☐	☐	_____
...currently taking any medication(s)?	☐	☐	_____
...having difficulty interacting with others?	☐	☐	_____

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?

_____

What changes (if any) in your child's health or behavior would you like accomplished?

_____

Authorization for Care of a Minor Child

I hereby authorize my child's doctors in this chiropractic office, including whomever they deem their assistants, to work with my child's condition through the use of adjustments and procedures the doctor deems appropriate.

I clearly understand and agree that all services rendered to my child are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my child's care, any fees for professional services rendered to my child will become immediately due and payable. I hereby authorize assignment of my child's insurance rights and benefits (if applicable) directly to the provider for services rendered.

_____ _____

Parent or legal guardian's name (print) Patient's name (print)

_____ _____ _____

Parent / Guardian's signature Date Witness' signature

Ownership of X-ray films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while my child is a patient of this office.