HARMONIOUS LIVING CHIROPRACTIC: FITNESS & WELLNESS CENTER, LLC

Location: 603 7th Street, Unit 301, Laurel, Maryland 20707
Tel: (240) 264 – 6372 Fax: (240) 264 – 6431 Email: info@drtiffanybutler.com

PEDIATRIC REGISTRATION FORM

(**Please Print**)

Today's Date: / /	**Patient Account No:**

CHILD'S INFORMATION

↓ Last Name:	↓ First Name:	↓ M.I.

Parent/Legal Guardian Name(s):	Home Phone	Parent's Cell Phone	Birth date:	Age:	Sex:	
			/ /		❑ M	❑ F

Street Address:	P.O. Box:	Social Security #:
		/ /

City:	State:	ZIP Code:	Parent's Email Address:

Can we send reminders through text message and/or e-mail?	❑ Yes ❑ No	How did you hear about us? (please check)	❑Internet ❑ Flyer ❑ Referral ❑ Friend/Relative ❑ Other: _____

Student: ❑ YES ❑ NO *What grade?* _____	**Does your child play organized sports?** ❑YES ❑NO	***What sports?*** ❑ Basketball ❑ Baseball ❑Football ❑ Soccer ❑Swim ❑ Lacrosse ❑ Field Hockey ❑ Volleyball ❑ Golf ❑ Cheerleading ❑ Gymnastics ❑ Softball ❑ Track & Field ❑ Cross Country ❑Tennis ❑Weightlifting ❑ Wrestling ❑Martial Arts

Emergency Contact Name & Number:	
Pediatrician Name and Clinic Name:	
Why have you decide to have your child evaluated by a Chiropractor?	❑ He/She is continuing ongoing care from another chiropractor. ❑ I recently had my spine checked/saw a chiropractor and understand the value in getting my child checked. ❑ I have concerns about his/her health and I'm looking for answers. ❑ He/She has a specific condition and I've learned that chiropractic may be able to help.

CHILD'S COMPLAINTS (please mark areas of complaint)

	Muscle and Joint ❑ Headache (e.g. Migraines, Tension) ❑ Neck ❑ Mid-Back ❑ Lower Back ❑Jaw ❑ Shoulder (Right/Left/Both) ❑ Arm (Right/Left/Both) ❑Elbow (Right/Left/Both) ❑ Wrist (Right/Left/Both) ❑ Hip (Right/Left/Both) ❑ Leg (Right/Left/Both) ❑Knee (Right/Left/Both) ❑ Ankle (Right/Left/Both) ❑ Hand (Right/Left/Both) ❑ Foot (Right/Left/Both) ***Other*** ❑ Dizziness ❑ Nausea ❑ Vomiting ❑Difficult Thinking ❑ Confusion ❑ Off-Balance ❑ Un-coordinated ❑ Weakness ❑ Digestive Issues ❑ Poor Posture ❑ Other: _____
How long have you had this condition?	❑ Just started ❑ Few Days ❑ Few Weeks ❑ Months ❑ Years
Is the condition?	❑ Getting better ❑ Getting worse ❑ Stays the same
What seem to be the initial cause of this condition?	

PAST MEDICAL HISTORY

Does your child have any past or present health issues? ❑ Yes ❑ No	*If yes, please list.*

LIFESTYLE

Does your child take minerals, herbs, vitamins or supplements? If ***yes,*** please indicate.	❑ Yes ❑ No
How would you rate your child's health?	❑ Poor ❑ Fair ❑ Good ❑ Excellent

SOCIAL HISTORY

Does your child do at least 20-30 minutes of physical activity every day?	❑ Yes ❑ No
How many hours of sleep does your child get?	❑ 4-8 hours/ night ❑ 8+ hours/night ❑ Difficulty Sleeping

FAMILY HISTORY (IF ANY BLOOD RELATIVES HAVE CONDITION, PLEASE MARK)

❑ Asthma ❑ Emphysema ❑ High Blood Pressure ❑ Diabetes ❑ Stomach Problems ❑ Thyroid Disease ❑ High Cholesterol
❑ Heart Attack ❑ Stroke ❑ Arthritis-Rheumatism ❑ Circulation Problems ❑ Osteoporosis ❑ Kidney Disease
❑ Mental Disorder ❑ Cancer ❑ Other: _____

Do you have any other health issues or concerns that our staff should be aware of? ❑ YES ❑ NO

ACCEPTANCE & AUTHORIZATION TO TREAT A MINOR

Have your child ever received chiropractic care before?	❑ Yes ❑ No

I understand and agree that the doctors of **HARMONIOUS LIVING CHIROPRACTIC: FITNESS & WELLNESS CENTER, LLC** have the right to refuse to accept my child as a patient at any time before treatment begins. The taking of history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so the doctor can determine whether to accept my child as a patient.

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my child.

_____ _____ _____
Printed Parent/Legal Guardian Name Signature of Parent/Legal Guardian Date

FINANCIAL AGREEMENT

I understand that I AM PERSONALLY RESPONSIBLE FOR FULL PAYMENT of all charges and fees by this office and I agree to pay for all services provided.

_____ _____ _____
Printed Parent/Legal Guardian Name Signature of Parent/Legal Guardian Date