Next Level Chiropractic & Wellness

625 N. State St., Ste. B · Caro, MI 48723 · (989) 208-3847

PATIENT INTAKE

Children Intake & Health History

About the Patient

Name _____ Today's Date _____ Birthdate _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ Gender ☐ M ☐ F

Significant Other's Name _____ Kid's Names and Ages _____

Your Employer _____ Type of Work _____

E-mail Address _____ Have you been to a chiropractor before? ☐ No ☐ Yes

Emergency Contact _____ Ph # _____

Name of Medical Doctor(s) _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Next Level Chiropractic & Wellness to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- **Person responsible for this account if other than the patient?** _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- **For my balance my preferred payment method is:** ☐ Cash ☐ Check ☐ Credit Card ☐ Car/Work Ins.

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) **Date**

Reason for Seeking Care

Present complaints

1 **Complaint** _____ **How long has this been an issue?** _____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse

☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening **Pain radiates to** _____

2 **Complaint** _____ **How long has this been an issue?** _____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse

☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening **Pain radiates to** _____

3 **Complaint** _____ **How long has this been an issue?** _____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse

☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening **Pain radiates to** _____

4 **Complaint** _____ **How long has this been an issue?** _____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse

☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening **Pain radiates to** _____

5. Does your condition affect: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ Driving

6. What makes it better? _____

7. What makes it worse? _____

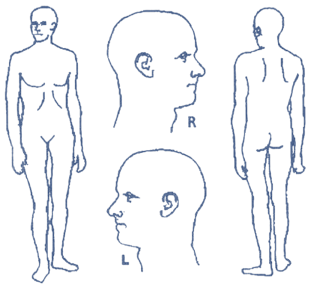
8. What Doctor's have you seen for this? _____

9. Type of treatment: _____

10. Results: _____

Notes: _____

Please mark all areas of concern.



Are you pregnant? ☐ Yes ☐ No

General Health History

Patient Name _____ Mark the conditions that apply to you.

PAST	PRESENT		PAST	PRESENT	
☐	☐	Headaches	☐	☐	Vision Problems
☐	☐	Ear Infections	☐	☐	Sleeping Problems
☐	☐	Colic	☐	☐	Growing Pains
☐	☐	Allergies / Asthma	☐	☐	Dental Problems
☐	☐	Medication Side Effects	☐	☐	Temper Tantrums
☐	☐	Recurring Fevers	☐	☐	ADHD
☐	☐	Digestive problems	☐	☐	Seizures
☐	☐	Bed Wetting	☐	☐	Scoliosis
☐	☐	Chronic Colds/Sinus	☐	☐	Ever Needed Stitches

☐ ☐ Other _____

HEALTH & BIRTH HISTORY

1. List any medications being taken: _____
2. Number of courses of Antibiotics child has taken in the last 6 mo. _____ Total during lifetime _____
3. Name of Pediatrician and Other Doctors: _____
4. Date of Last Visit ___ / ___ / ___ Reason: _____
5. Name of Obstetrician/Midwife: _____
6. Location of Birth: ☐ Hospital ☐ Birthing Center ☐ Home
7. Complications During Pregnancy: ☐ No ☐ Yes If yes, explain: _____
8. Ultrasounds During Pregnancy: ☐ No ☐ Yes If yes, how many: _____
9. Medication During Pregnancy / Delivery ☐ No ☐ Yes If yes, list: _____
10. Cigarette / Alcohol Use during Pregnancy: ☐ No ☐ Yes
11. Has any Doctor / Other Professional advised you to "Take the child to a Chiropractor"? ☐ No ☐ Yes

    If yes, Name _____

Past History

12. List any past auto collisions: _____ Was any care received? _____
13. List any past falls bumps bruises: _____ Was any care received? _____
14. List any past sport, recreational, or home injuries: _____
15. Please describe any past conditions and treatment received: _____

    _____
16. Please list any past hospitalizations and surgeries: _____

    _____

Family History

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis Other _____

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis Other _____

Is there any other family history you want us to know? _____

_____