Welcome to CROWLEY HIROPRACTIC LINIC

Health and Wellness thru the 5 Essentials,

the way Nature intended.

(912) 265-2129

CROWLEY CHIROPRACTIC CLINIC
597 Palisade Drive
Brunswick, GA 31523 (912) 265-2129

CHILD MEDICAL DATA (5-17)

Please fill out the best of your ability. Whom may we thank for referring you to our office? _____

Thank you for the opportunity to serve you, *Team Crowley*

Full Name: _____ Nickname: _____ Today's Date: _____

DOB: _____ Age: _____ Social Security #: _____ ☐Male ☐Female

Address: _____ City: _____ State: _____ Zip: _____

Phone (Home): _____ Mothers (or other) mobile: _____ Fathers (or other) mobile: _____

Primary Care Giver: ☐ Mother ☐ Father ☐ Other *(please explain)* _____

Pediatrician/Family MD: _____ City & State: _____ Last Visit: _____

Purpose of last visit: _____

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

Ever been under chiropractic care? ☐ No ☐ Yes: Who/When? _____

Who is responsible for this bill? ☐ Mother ☐ Father ☐ Other _____ ☐Male ☐Female

Do you have Insurance: ☐ Yes ☐ No

Full Name: _____ SS#: _____

DOB: _____ Phone: _____ Email: _____

Address if other than above: _____ City: _____ ST: _____ Zip: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Unknown
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race ☐ PT Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ PT Declined ☐ Unknown

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

CHILD'S CURRENT SITUATION

What Vitamins/Nutritional Supplements is child taking?

What medications is child taking?

What medications is child allergic to?

Has child had an outpatient visit with their Primary Physician or OB/GYN within the last year and been documented with a BMI resulting in nutritional and/or physical activity counseling? ☐ No ☐ Yes If yes when? _____ By Whom: _____

Has child been diagnosed with mild, moderate, or severe persistent asthma and prescribed an inhalant medication(s)? ☐ No ☐ Yes

Purpose of this visit: ☐ Wellness ☐ Check-up ☐ Other: _____

If 13 or older, Tobacco: ☐ cigars ☐ pipe ☐ cigarettes ☐ chew → ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never ☐ Used To

IF THIS VISIT IS ANYTHING OTHER THAN WELLNESS, PLEASE COMPLETE **HISTORY of COMPLAINT** BELOW, OTHERWISE SKIP TO **CHILD HISTORY**

HISTORY of COMPLAINT

Please (as specifically as possible) identify the problem(s) that brought you to our office:

Primary: _____ (_____) Secondary: _____ (_____)

Third: _____ (_____)

On a scale of **1** to **10** with **10** being the worst pain, rate your above complaints by adding it in the parenthesis provided above.

NAME: _____ SIGNATURE: _____ DT: _____

□ Check if you are Guardian of PT HRN: _____ DR INT: _____ DT: _____

Onset of Primary Problem: Date _____ ☐ Unknown ☐ Gradual ☐ Sudden

When is the problem at its worst? ☐ AM ☐ mid-day ☐ PM ☐ late PM

☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

Ever had this problem before? ☐ No ☐ Yes If yes when? _____

How is this problem **NOW:** ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ On & Off

Onset of Secondary Problem: Date: _____ ☐ Unknown ☐ Gradual ☐ Sudden

Ever had this problem before? ☐ No ☐ Yes If yes when? _____

How is this problem **NOW:** ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ On & Off

Any bowel or bladder problems since problems began?: ☐ No ☐ Yes *(Describe)*: _____

Any medication taken for problems? ☐ No ☐ Yes: _____

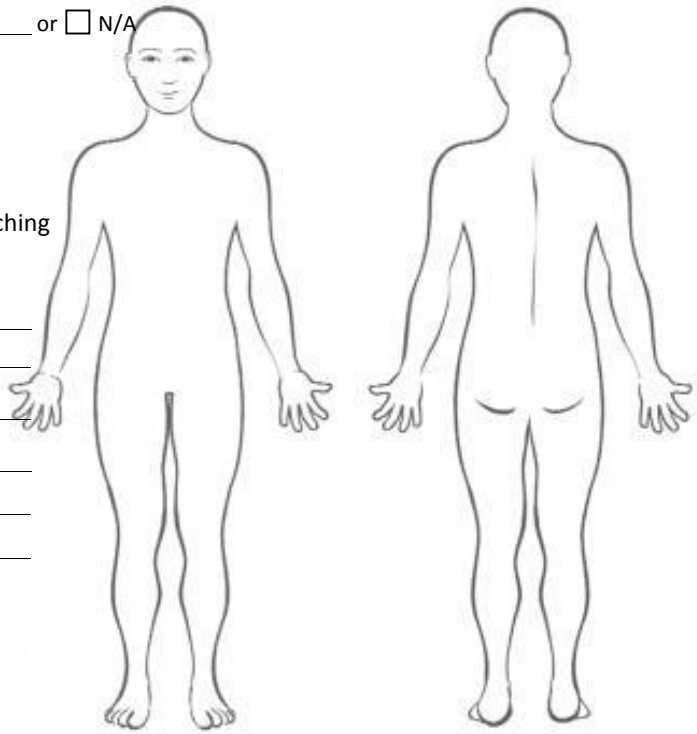
Condition(s) ever been treated before? ☐ Yes ☐ No If yes, when: _____ By whom? _____

How long were you under care: _____ What were the results: _____

Name of Previous Chiropractor: _____ or ☐ N/A

Please **Mark** the areas on the Body Diagram with the following letters to describe your symptoms:

R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = Aching
N = **N**umbness **S** = **S**harp/ **S**tabbing **T** = **T**ingling



What relieves your symptoms? _____

_____

_____

What makes them feel worse? _____

_____

_____

DAILY ACTIVITIES: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking/Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

NAME: _____ SIGNATURE: _____ DT: _____

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CHILD'S HISTORY

AT WHAT AGE, IF EVER, DID CHILD SUFFER FROM THE FOLLOWING:

Chicken pox: _____ Mumps: _____ Measles: _____ Rubella: _____ Whooping Cough: _____ Other: _____

HAS YOUR CHILD EVER SUFFERED FROM:

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Allergies to _____
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Allergies to _____
☐ Asthma	☐ Scoliosis	☐ Anemia	☐ Allergies to _____
☐ Colds/Flu	☐ Walking Trouble	☐ Bed Wetting	☐ Other: _____
☐ Colic	☐ Broken Bones	☐ Sleeping Problems	☐ Other: _____

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS:

☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall off skateboard or skates
☐ Fall from crib	☐ Fall off swing	☐ Fall off bicycle
☐ Fall from high chair	☐ Fall off slide	☐ Fall down stairs
☐ Fall from changing table	☐ Fall off monkey bars	☐ Other: _____

Has your child ever sustained an injury playing organized sports? ☐ Yes ☐ No If yes; please explain _____

Has your child ever sustained an injury in an auto accident? ☐ Yes ☐ No if yes; please explain _____

PLEASE identify ALL PAST and any CURRENT conditions:

ISSUE	WHEN	TYPE OF CARE RECEIVED
INJURIES →		
INJURIES →		
SURGERIES →		
SURGERIES →		
CHILDHOOD DISEASES →		

FAMILY HISTORY

Please indicate if your child or a family member has had any of the following: *Check "C" for child, "F" for family member:*

☐ C/☐ F Heart Disease	☐ C/☐ F Diabetes	☐ C/☐ F Stroke
☐ C/☐ F Cancer	☐ C/☐ F High / Low blood pressure	☐ C/☐ F Asthma
☐ C/☐ F Gastrointestinal disease	☐ C/☐ F Memory/mood disorder	☐ C/☐ F Thyroid problem

I understand that, as the signing guardian, I am directly and fully responsible to Crowley Chiropractic Clinic for all chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

Client agrees that this Maximized Living Health Center does not provide legal services, advice or counsel. Some advice, advertising and materials provided by this Maximized Living Health Center may have legal implications. Client agrees to seek independent legal counsel before implementing said advice, advertising and materials. Client agrees to hold this Maximized Living Health Center harmless from any legal action taken by others against the Client for any Client implementation that caused in whole or in part said legal action. Client assumes all liability and responsibility for Client compliance to any State or Federal law, rule or their interpretation thereof by the governing authority.

NAME: _____ SIGNATURE: _____ DT: _____

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