

**PATIENT INFORMATION**

Please complete the following forms to the best of your knowledge. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help you.

Patient's Full Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender: \_\_\_Female \_\_\_Male

Are You: \_\_\_Minor \_\_\_Single \_\_\_Married \_\_\_Separated \_\_\_Divorced \_\_\_Widowed

May we contact you via e-mail?  Yes  No

(Monthly Newsletters, Appt. Reminders, Updates, Schedule Changes)

E-Mail Address: \_\_\_\_\_

Your Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Workplace: \_\_\_\_\_ Work Phone \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Workplace: \_\_\_\_\_ WorkPhone \_\_\_\_\_  
(If a minor)

Father's Name: \_\_\_\_\_ Workplace: \_\_\_\_\_ Work Phone \_\_\_\_\_  
(If a minor)

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Whom may we thank for referring you to us: \_\_\_\_\_

**Insurance Information**

Check here if you currently have no insurance

If we have taken a copy of your insurance card it is not necessary to fill out the insurance part of this form.

Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Relationship To Patient: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

*Thank you for choosing our practice for your chiropractic needs.*

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**CHIROPRACTIC INFORMED CONSENT FOR DIAGNOSIS AND TREATMENT**

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my condition(s).

Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, physiotherapies, and soft tissue therapies. Like most health care procedures, the therapies carry with them some risks. Unlike many such procedures, the serious risks associated with the therapies are extremely rare. Following are the known risks:

**Temporary soreness or increased symptoms or pain.** It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.

**Dizziness, nausea, flushing.** These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.

**Fractures.** When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

**Disc herniation or prolapse.** Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

**Stroke.** Previous research has suggested an association between cervical spine manipulation and stroke on extremely rare occasions. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care.

Other risks associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

**OFFICE USE ONLY**

Based on my personal observation and the patient's history and physical exam, I conclude that throughout the informed consent process the patient was:

- Of legal age
- Consent given through Guardian
- Oriented x3
- Appears unimpaired
- Fluent in English
- Assisted by a translator or interpreter

\_\_\_\_\_  
Signature of Translator or Interpreter, if applicable

\_\_\_\_\_, D.C.  
Signature of Chiropractor

\_\_\_\_\_  
Date

**FAMILY MEDICAL HISTORY**

**Please check if any blood relatives to the patient have/had any of the following illness and mark as follows:**

**M=Mother F=Father S=Sibling PGM=Paternal Grandmother MGM=Maternal Grandmother**  
**PGF=Paternal Grandfather MGF=Maternal Grandfather**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Allergy, Asthma, or Eczema | <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Diabetes or Low Blood Sugar |
| <input type="checkbox"/> Heart Trouble              | <input type="checkbox"/> High Blood Pressure/Stroke | <input type="checkbox"/> Kidney Disease              |
| <input type="checkbox"/> Liver Disease              | <input type="checkbox"/> Developmental Delay        | <input type="checkbox"/> Mental Illness              |
| <input type="checkbox"/> Scoliosis                  | <input type="checkbox"/> Ulcer                      | <input type="checkbox"/> Other_____                  |

**PREGNANCY**

**Please check any areas that applied to the patient's mother during her pregnancy:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Complications      | <input type="checkbox"/> Premature Contractions | <input type="checkbox"/> Attitude-Mostly Depressed |
| <input type="checkbox"/> Medications        | <input type="checkbox"/> Excessive Weight Loss  | <input type="checkbox"/> Attitude Mostly Happy     |
| <input type="checkbox"/> Recreational Drugs | <input type="checkbox"/> Excessive Weight Gain  | <input type="checkbox"/> Carried to Full Term      |
| <input type="checkbox"/> Smoking            | <input type="checkbox"/> Toxic Exposures        | <input type="checkbox"/> Chiropractic Care         |
| <input type="checkbox"/> Alcohol            | <input type="checkbox"/> Allergic Reactions     | <input type="checkbox"/> Hospitalization           |
| <input type="checkbox"/> Caffeine           | <input type="checkbox"/> Mental Trauma          | <input type="checkbox"/> Any Diagnosed Illness     |
| <input type="checkbox"/> Vitamins/Minerals  | <input type="checkbox"/> Physical Injury        | <input type="checkbox"/> Immunization              |
| <input type="checkbox"/> Back Pain          | <input type="checkbox"/> Prenatal Classes       | <input type="checkbox"/> Bleeding                  |
| <input type="checkbox"/> Other Pain         |   |  |

**LABOR & DELIVERY**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Greater than 12 Hours | <input type="checkbox"/> Complications | <input type="checkbox"/> Fetal Monitor Used |
| <input type="checkbox"/> Medications           | <input type="checkbox"/> Forceps       | <input type="checkbox"/> Caesarian          |
| <input type="checkbox"/> Hospital              | <input type="checkbox"/> Home Birth    | <input type="checkbox"/> Premature Delivery |
| <input type="checkbox"/> Vacuum Extraction     |  |   |

**PRENATAL HISTORY**

Duration of Pregnancy: \_\_\_\_\_weeks. Birth Weight: \_\_\_\_\_lb\_\_\_\_\_oz Birth Length\_\_\_\_\_in  
Apgar Score at Birth\_\_\_\_\_ Apgar Score at 5 minutes\_\_\_\_\_

**Please check any problems the patient had at birth:**

- |                                    |                                     |                                   |
|------------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Coloring   | <input type="checkbox"/> Crying   |
| <input type="checkbox"/> Choking   | <input type="checkbox"/> Nursing    | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Jaundice  | <input type="checkbox"/> Other_____ |                                   |

**Please check if any item(s) applied to the patient at birth:**

- |                                     |   |                                       |
|-------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Medication | <input type="checkbox"/> Artificial Feeding | <input type="checkbox"/> Vitamin K    |
| <input type="checkbox"/> Surgery    | <input type="checkbox"/> Erythromycin       | <input type="checkbox"/> Circumcision |
| <input type="checkbox"/> Other_____ |   |                                       |

**NUTRITION**

**Please check if the patient has received any of the following items:**

- |                                      |                                      |  |
|--------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Breast Milk | <input type="checkbox"/> Commercial  | <input type="checkbox"/> Cow's Milk      |
| <input type="checkbox"/> Goat's Milk | <input type="checkbox"/> Other Milk  | <input type="checkbox"/> Solid Foods     |
| <input type="checkbox"/> Sweets      | <input type="checkbox"/> Fruit Juice | <input type="checkbox"/> Vegetable Juice |
| <input type="checkbox"/> Vitamins    | <input type="checkbox"/> Supplements | <input type="checkbox"/> Medications     |
| <input type="checkbox"/> Other_____  |                                      |  |

\_\_\_\_\_  
**Patient's Name**

\_\_\_\_\_  
**Signature of Parent or Guardian**

\_\_\_\_\_  
**Date**

**CHILD HEALTH QUESTIONNAIRE**

**GENERAL SYSTEM REVIEW**

Has your child ever been unconscious or had a convulsion?  1 Yes  2 No

If yes, please explain: \_\_\_\_\_

Has your child had problems with the eyes, including vision?  1 Yes  2 No

If yes, please explain: \_\_\_\_\_

Has your child ever been cyanotic? (Turned Blue)  1 Yes  2 No

If yes, please explain: \_\_\_\_\_

Does your child tolerate exercise?  1 Yes  2 No

Does your child have recurring problem with vomiting, diarrhea, constipation, or stomach pain?  1 Yes  2 No

If yes, please explain: \_\_\_\_\_

Do your child's stools look or smell abnormal?  1 Yes  2 No

If yes, please explain: \_\_\_\_\_

Does your child have any unusual problem on passing urine or any unusual frequency?  1 Yes  2 No

If yes, please explain: \_\_\_\_\_

Does your child have any unusual smell or appearance of urine?  1 Yes  2 No

If yes, please explain: \_\_\_\_\_

Does your child complain of an extremity or back pain?  1 Yes  2 No

If yes, please indicate where: \_\_\_\_\_

Do you notice a limp or unusual gait pattern when your child walks?  1 Yes  2 No

If yes, please explain: \_\_\_\_\_

Does your child have any allergies, eczema, hay fever, hives, asthma, or drug reactions?  1 Yes  2 No

If yes, please explain: \_\_\_\_\_

(701) 492-0696

The Clinic: Family Health & Sports Chiropractic  
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**Dr. Aaron Jones • Dr. Tim Stark**  
**Dr. Paul Bekkum • Dr. Andrea Burckhard**

[www.WFSportsCare.com](http://www.WFSportsCare.com)

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**CHILD HEALTH QUESTIONNAIRE-2**

**IMMUNIZATION**

Please list any immunizations that the patient has received along with the date it was received and any reactions observed:

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**ILLNESSES**

Please list any previous illnesses the patient has had along with the date:

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**FAMILY PHYSICIAN**

Name of pediatrician and date of last exam:

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**REASON FOR TODAY'S VISIT**

Reason for visit:

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When did you notice your child's the symptoms?

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Is this condition getting progressively worse?     1 Yes     2 No

If yes, please explain: \_\_\_\_\_

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What treatment, if any, has the patient already received for this condition?

Medication       Surgery       Physical Therapy       Other

Name and facility of the other doctor(s) who have treated the patient for this condition:

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