Integrative Family Wellness Center

16535 W. Bluemound Rd. Suite 222
Brookfield, WI 53005
P-262-754-4910 F-262-754-4913

Please Print

Patient Name________________Date of Birth __________
Email________________Male/Female__________
Cell Phone__________Work__________Home__________
Address________________Apartment__________
City__________State__________Zip Code__________
~~Driver's License #________________Social Security #__________~~
Employer__________________________
Work Address__________________________
Spouse__________________________
Spouse Employer________________Phone__________
Work Address__________________________
Spouse Birthdate________________Social Security #__________
Primary Insurance________________CoPay__________
Policy Holder Name________________Effective Date__________
ID Number________________Group Number__________
Policy Holder Date of Birth__________Policy Holders Social Security #__________
Secondary Insurance__________________________
Policy Holder Name________________Effective Date__________
ID Number________________Group Number__________
Policy Holder Date of Birth__________Policy Holders Social Security #__________
If Minor or College Student:
Responsible Parent________________Date of Birth__________
Address if different from Parent________________Phone__________
City__________State__________Zip Code__________
Emergency Contact Name________________Phone__________
Referred By__________________________
Primary Doctor________________Phone__________
Pharmacy________________Phone__________
Allergies or Sensitivities__________________________
Blood Type__________________________
How Did You Hear About Us?__________________________

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement of this agreement shall be as valid as the original.

Signature____________________Date__________

Date and Initials:________ ________ ________ ________ ________

Chiropractic New Patient Registration –Over 12 years old

Name______________________________________Sex M F Date________________________

Address__________________________________City___________________State______Zip______________

H. Phone(_______)________________W. Phone________________ Date of Birth______________Age________

Referred by_______________________________________Social Security #________________________

Occupation_______________________________________Employer____________________________

Have you ever received Chiropractic Care? Yes No If yes, when?______________________

1. **Primary reasons for seeking chiropractic care:**

Primary reason: ____

Secondary reason: ____

Other factors contributing to the primary and secondary reasons: ____________________________

2. **Chief Complaint:** ____

Location of Complaint: ____

Complaint Began when and how? ____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other ______

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?______________________

Do you have any numbness or tingling in your body? Where? ____________________________

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? ______________________________

Does anything aggravate the complaint? ____

Does anything make the complaint better? ____

3. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:** ____________

____

____

4. **Past Health History:**

A. **Previous illnesses you've had in your life:** ____

____

B. **Previous injury or trauma:**____

____

-------- OVER-------

Have you ever broken any bones? Which? ____

Chiropractic Child History Form

Date: ___________

Please complete this detailed history form and return it to the receptionist. Should you require any assistance, please let us know as we will be happy to assist.

Child's Name: ______________________ Home Telephone: ______________
Street Address: ____
City: ______________________ Zip Code: ______________
Doctor's Name: ______________________ Doctor's Location: ______________

Previous Chiropractor: ______________
Date of Last Visit: ______________

Child's Height: ______________ Child's Weight: ______________

Name of Parent(s) or Guardian(s): ______________________
Parents Work Phone: ______________________

I hereby authorize and consent to the chiropractic evaluation and care of my child, ______________
Parent or Guardian Signature: ______________________
Witness: ______________

What are your chief concerns, if any, with your child's health? ______________

What is your main reason for contacting us? ______________

List any other care your child has undergone with regards to this complaint including medications: ______________

Date of onset: ______________

Onset was: (circle one)		
Sudden	Gradual	Associated with an event

Duration of Complaint/Episode: (circle one)				
Minutes	Hours	Days	Months	Years

Pattern of Problem: (circle one)			
Constant	Intermittent	Occasional	Cyclical

Initiating Factors: ______________

Aggravating Factors: ______________

How does the problem affect your child's body function and daily activities? ______________

Prior occurrence or episodes? ______________

Other health concerns? ______________

OVER

History of Birth

Hospital/Birthing Center: Home Medical Midwife Duration of Gestation: ________ weeks

Was the birth assisted: Yes No If yes, how? Forceps Vacuum C-section Induced

Were meds given to the mother at birth? Yes No If yes, what? __________ Duration of Birth: __________

Was the delivery normal? No Yes What complications were there at birth? __________

APGAR at Birth: ________ APGAR after 5 minutes: ________ Birth Weight: ________ Birth Length: ________

Growth and Development

~~Was the infant alert & responsive within 12 hours of the delivery? Yes No If no, explain:~~ __________

At what age did the child: Respond to sound? Follow an object? Hold up head?
Vocalize? Sit Alone? Teeth? Crawl?
Walk? Do his/her sleeping patterns seem normal? Yes No

Describe any health problems that exist on the mother's side of the family? (e.g. Cancer, Diabetes, etc.) __________

Father's Side? __________

Do the child's siblings have any health problems Yes No If yes, describe: __________

The following info is very important because many of the problems that chiropractors work with are caused by stress.

Chemical Stressors

During pregnancy, did the mother: Smoke: Yes No Drink alcohol: Yes No
Take supplements/vitamins: Yes No Receive Ultrasounds: Yes No # given: ________
Receive invasive procedures (i.e. amniocentesis, CVS) Yes No

Was your child breast fed? Yes No If yes, for how long? ________ weeks months years

At what age was: Formula Introduced: ________ Brand: ________ Cow's Milk: ________
Solid Food: ________

Did your child receive vaccinations? Yes No Which ones? __________

Has your child had antibiotics? Yes No How often? __________

Any pets at home? Yes No Any Smokers? Yes No How much? ________

Psychological Stressors

Any difficulties with lactation? Yes No Any problems bonding? Yes No

Does your child seem normal to you? Yes No Does your child have any behavior problems? Yes No

Does your child have any problems sleeping? Yes No If yes, specify: __________

Did your child go to daycare? Yes No From what age? ________

Average # of hours on TV/Computer per week? ________

Traumatic Stressors

Any evidence of trauma during birth? Bruises Odd shaped head Stuck in birth canal
Fast or long birth? Respiration depression Cord around neck
Other: __________

Any falls/accidents during pregnancy? Yes No Has the child had any major falls since birth? Yes No

Has the child needed stitches or have a fracture? Yes No Explain? __________

Any hospitalizations? __________

Does your child play sports? Yes No Number of hours/week? ________ Age of starting? ________

Weight of school backpack? ________ Hours spent at play per week? ________