Lark Chiropractic

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to create better health for your family.

(Please Print)

Patient Name:_____

Address:_____City:_____ State:_____ Zip:_____

Home Phone: (_____)_____ Cell: (_____)_____ Work: (_____)_____

Date of Birth: ____/____/____ S.S.#_____-____-_____ Gender: □ Female □ Male Height:_____ Weight:_____

Parent(s)/Guardian Name(s): _____ Referred By:_____

Purpose for Contacting Us? _____

Have Other Doctors Been Seen for this Condition? □ Yes □ No If Yes, List Doctor Name(s) and Prior Treatments:

_____

_____

Any Other Health Problems?_____

Check Any of the Following Conditions Your Child Has Experienced During the Past Six Months:

□ Ear Infections	□ Digestive Problems	□ Car Accident	□ Headaches
□ Asthma / Allergies	□ Bed Wetting	□ Chronic Colds	□ Growing / Back Pains
□ Colic	□ Seizures	□ Recurring Fevers	□ Autism
□ Scoliosis	□ ADD/ADHD	□ Temper Tantrums	□ Other:_____

Family History:_____

Previous Chiropractor (If Any):_____ Date of Last Visit:_____

Reason:_____

Are You Satisfied with the Care Your Child has Received There: □ Yes □ No

Name of Pediatrician:_____ Date of Last Visit:_____

Reason:_____

Are You Satisfied with the Care Your Child has Received There: □ Yes □ No
# of Antibiotics Your Child has Taken During the Past Six Months: _____ During His/Her Lifetime: _____
# of Doses of Other Prescription Medications Your Child has taken: During the Past Six Months: _____
During His/Her Lifetime: _____ Please List:_____
Vaccination History: _____

Prenatal History:

Name of Obstetrician/Midwife:_____
Complications During Pregnancy: □ Yes □ No List:_____
Ultrasounds During Pregnancy: □ Yes □ No Number:_____

Medications During Pregnancy/Delivery: □ Yes □ No List:_____
Cigarette/Alcohol Use During Pregnancy: □ Yes □ No
Location of Birth: □ Hospital □ Birthing Center □ Home
Birth Intervention: □ Forceps □ Vacuum Extraction □ Caesarian Section If C-Section: □ Emergency □ Planned

Complications During Delivery: □ Yes □ No List:_____

Genetic Disorders or Disabilities: □ Yes □ No List:_____

Birth Weight:_____ Birth Length:_____ APGAR Scores:_____ _____

Feeding History:

Breast Fed: □ Yes □ No How Long? _____
Formula Fed: □ Yes □ No How Long?_____ What Type?_____
Introduced to Solids at _____ Months Introduced to Cows' Milk at _____ Months
Food/Juice Allergies or Sensitivities: □ Yes □ No List:_____

Developmental History:

During the following developmental stages your child's spine is most vulnerable to stresses and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

Sit Up:_____ Stand Alone:_____ Hold Head Up:_____ Walk Alone:_____

Cross Crawl:_____ Respond to Sound:_____ Respond to Visual Stimuli:_____

According to the National Safety Council, approximately 50% of children fall head-first from a high place during their first year of life (for example: a bed, changing table, stairs, etc.). Has your child had a head-first fall? □ Yes □ No

Is/has your child been involved in any high impact or contact sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? □ Yes □ No List:_____

Has Your Child Ever Been Involved in a Car Accident? □ Yes □ No List:_____

Has Your Child Been Seen on an Emergency Basis? □ Yes □ No List:_____

Other Traumas Not Described Above? □ Yes □ No List:_____

Prior Surgery: □ Yes □ No List:_____

Menarche : □ Yes □ No Age:_____

Childhood Diseases: Please mark all that apply.

☐ Chicken Pox Age:_____ ☐ Mumps Age:_____
☐ Rubella Age:_____ ☐ Whooping Cough Age:_____
☐ Rubeola Age:_____ ☐ Other(s) List:_____

Authorization for Care of Minor

I hereby authorize this office and its Doctors and Staff to administer Chiropractic care to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees at the time services are rendered.

Name of Parent/Guardian:_____ Date: _____

Signature of Parent/Guardian:_____

CONSENT TO TREATMENT OF A MINOR CHILD

I hereby authorize: Dr. Sharon Lark and whomever he or she may designate as assistants to administer chiropractic care as deemed necessary to consent to any x-ray examination and chiropractic diagnoses or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general special supervision of any licensed chiropractor, to my _____

(Name of child)

This _____ day of_____20_____

Dated at _____

(City) (State)

Signed_____

Relationship to child _____