WELCOME to Gowrie Family Chiropractic and THANK YOU for your interest as a patient in our clinic. Our methods have enabled our patients to achieve their goals. Once we have determined we can help you, we will come up with a plan so your health is a top priority. Thank you again for your interest in becoming a patient in our clinic.

Patient Name

Date

Personal Information

Child Name: _____ Parent/guardian

Name:_____

Birth Date: _____/_____/_____ Age: _____ Gender: M F

Home Address:

_____

City, State,

Zip:_____

Parents Phone:_____ Parents

Email:_____

Social Security #: _____-_____-_____

Is your parent/guardian a patient in the clinic? ____ Yes ____ No

Has your child seen a Chiropractor before? ___ Yes ____ No

Who?_____

Emergency Contact:

Contact name:_____

Contact number:_____

Complications during pregnancy? ___ No ___ Yes, Explain:_____
Was your child in an intrauterine constraint position during birth? ____No ____Yes
please circle: Breech, transverse, brow
Was the delivery vaginal or via C-section? _____
Were any of the following used during pregnancy? ___Forceps ___Vaccum extraction ___Other

Health History

Does your child have a preferred sleeping position? ___No ___Yes,
Explain:_____
Does your child have any feeding difficulties? ____No ____Yes,
Explain:_____
Does your child cry often? ____No ____Yes,
Explain:_____
Does your child pass a lot of intestinal gas? ____No ____Yes
Does your child frequently arch his/her back? ____No _____Yes
Does your child show any sensitivity to food? ____No ____Yes,
Explain:_____

Purpose For The Visit

Check any of the following symptoms in which your child currently has had now or the past:

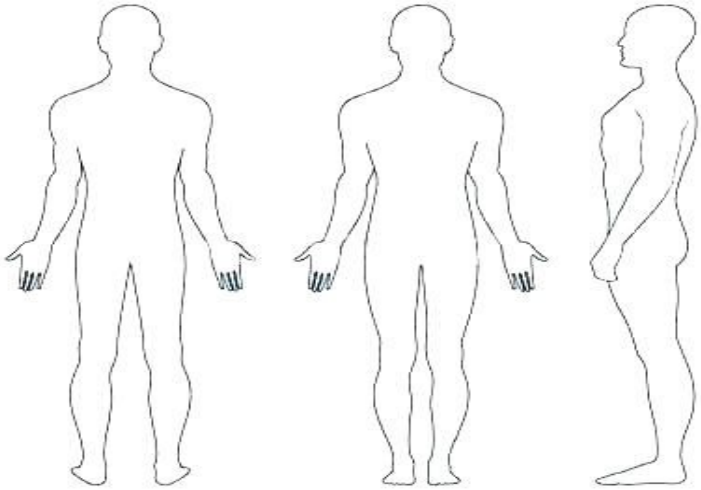
Y (yes) or N (no)

_____Asthma _____Colic _____Respiratory Tract Infection

_____Ear Infection	_____Strep Throat	_____Tonsillitis
_____Frequent Colds	_____Croup	_____Recurrent Fevers
_____Back Pain	_____Scoliosis	_____Frequently crying spells
_____Trouble sleeping	_____Bed Wetting	_____Tip Toe walking
_____Seizures	_____Shaking	_____Sinus Infection
_____Constipation	_____Neck Pain	_____Slow or absent reflexes
_____Headaches	_____Growing pains	_____Rashes/Eczema

When did these symptoms start? Month _____ Day _____ Year_____

How often do you experience your symptoms? ___Constantly ___Frequently ___Occasionally



Please use the following notations on the figures below to indicate the type and location of your symptoms, as it re;ates to the purpose of your visit today.

# = Numbness	X= Burning	/=Stabbing	0=Pins & Needles
+ = Dull Aches	S= Spams	F= Stiffness	T= Tingling

Please explain:

_____

_____

_____

_____

EHR Information:

Prefered Language_____ Ethnicity _____ Race_____

Current Medications/vitamins/supplements and Dosage

Medication Alligeries

___ I choose to decline receipt of my clinical summary after every visit

I clarify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my use of signed statement of authorization with m y signature for required insurance submissions. I understand and agree that all services rendered to me will be charges to me, and I'm responsible for timely payment between an insurance carrier and myself.I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature:_____ Date:_____

Gowrie Family Chiropractic & Acupuncture

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Chiropractic Care: I instruct the chiropractic to deliver the care in his or her professional judgement can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence are designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art form and does not proclaim to cure any disease entity.

Privacy Verification: I may request a copy of the privacy policy and understand it describes how my personal health information is protected and releases on my behalf for seeking reimbursements from any involved third parties.

Permission to be contacted: I granted permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letter, or health information to me as an extension of my care in the office.

Payment Verification: I acknowledge that any insurance I may have is an agreement between the carrier and provider and that I am responsible for the payment of any covered or noncovered services I receive.

General Verification: To the best of my ability, the information I have supplied is completed and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Printed Name:_____

Signature:_____

Witness:_____