

BELCHER CHIROPRACTIC CENTER

Pediatric Member Application (Birth to 12 Years)

Date _____ ID _____

Child's Name _____ Date of birth _____ Age _____

Parent/Guardian Name _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____

Gender: M F Student: ___ Full time ___ Part time SS# ____ - ____ - ____

Insured's Name _____ Birthdate: _____ SS# ____ - ____ - ____

Type of birth: _____ (Natural, Drug induced, Dr. induced, Breech, Forceps, Vacuum extraction, C-section)

Complications at birth? _____

How long was labor? _____ Was labor drug assisted? _____

Any delays in development? _____
(Holding head up, sitting up, crawling, standing up, walking, talking)

Breast-fed? _____ How long? _____ Eating habits: Excellent / Good / Poor

Reason for consultation:

____ Relief of Symptom ____ Correction of problem
 ____ Wellness care for optimizing health ____ Auto Injury? Date _____

Health Concern	What have you tried to solve this problem?

Please **check** any that are a part of child's health picture (past or present):

Allergies	Scoliosis	Muscular Dystrophy	Digestive Disorder
Asthma	Cerebral Palsy	Epilepsy/Seizures	Sinus Problems
Convulsions	Ear Infections	HIV Positive	Nervousness
Chronic Colds	Concussion	Backaches	ADHD
Diabetes	Headaches	Sleeping Problems	Fatigue
Fevers	Dizziness	Bed wetting	Mood Swings
Tonsillitis	Loss of Balance	Constipation	Depression
Croup/Colic	Buzzing in ears	Loss of smell	Irritability/Temper

Which contact sports does your child participate in?

Soccer Football Gymnastics Karate Hockey

Basketball Dance Other: _____

According to the National Safety Council, approximately 50% of infants fall head first from a high place (bed, changing table, etc.). Has this happened to your child? Y____ N____

How many prescriptions of antibiotics has your child taken:

During the past 6 months _____ Total during his/her lifetime _____

How many other prescription medications has your child taken:

During the last 6 months _____ Total during his/her lifetime _____

Are there smokers in the home? __Y __N

Is child vaccinated? __Y __N Any visible reactions? _____

I understand that insurance is an agreement between the insurance company & myself and that billing is done as a courtesy and is not a guarantee of payment. I agree to aid in timely collection from my insurance company and I understand that I am ultimately responsible for any unpaid balance on this account. I authorize Belcher Chiropractic Center to administer care as deemed necessary to the child named above and to release information as acquired in the course of examination or care to child named above. I certify that all information on this form is true and correct.

Parent/Guardian Signature _____ Date _____