



Spinal Decompression

Health History- Child

NAME _____ DATE _____

PARENTS/GUARDIANS _____

ADDRESS _____ CITY/PROV _____ P.C. _____

HOME PHONE _____ PARENT WORK PHONE/S _____

BIRTHDATE _____ OTHER SIBLINGS - NAMES/AGES _____

CARE CARD NUMBER _____

WHO REFERRED YOU TO US? _____

PAST CHIROPRACTIC CARE? YES/NO DR.'S NAME/LOCATION _____

LAST VISIT _____

CURRENT MEDICAL CARE? YES/NO WHY? _____

CURRENT DRUGS/MEDICATION _____

REASON FOR CONSULTING THIS OFFICE _____

**PLEASE CHECK THE CHOICE THAT MOST CLOSELY DESCRIBES
CURRENT GOALS FOR YOUR CHILD'S HEALTH/WELLBEING.**

- I am only concerned about relief of a particular symptom.
- I am only concerned about relief of a particular symptom, and preventing its return.
- I want optimum health and wellbeing on every level for my child.

WE ACCEPT PAYMENT BY CASH, CHEQUE, DEBIT, VISA AND MASTERCARD

I understand that all services are to be paid in full at the time of service,
unless other arrangements have been made and agreed upon in writing.

Signature _____ Date _____

