BACK 2 BACK CHIROPRACTIC

A Family Wellness Place

Dr. Steven Wallin, D.C.

Today's Date: ____________

Print Full Name: ______________________________ Name you go by: ______________
Parent's/Guardian's Names: ____
Street Address: __________________________ City: ______________ State: _____ Zip: _____
Age: ____ Height: ______ Weight: ______ Date of Birth: __________ Sex: Male☐ Female☐
Number of siblings __________ Patient's email address (if applicable) ______________________
Where did you hear about our office or who referred you? ______________________________

Phone Numbers:
Home: ______________ Parents Work: ______________ ext.____ Parent Cell: ______________
Parent/Guardian E-mail address: ____

Do you have medical insurance? Yes☐ No☐ Insurance Company Name: ______________________
Policy Number: ______________ Insurance Company Phone Number: ______________________
Insured's Name (if different from patient): ______________ Relationship to patient: ___________
Insured's Date of Birth: ______________ Insured's Social Security Number: ______________________

If you have no symptoms or complaints and are here for wellness services, please check ☐; otherwise briefly describe the reason for seeking chiropractic care: ______________________________

Is this due to an accident or injury? Yes☐ No☐ Date: ________ Type of accident: Auto☐ Other: ___________
Does it interfere with your (circle all that apply): Work/School Sleep Daily routine Exercise
Have you seen other doctors for this condition? Yes☐ No☐ Dr's name: ______________________
Please fill in the blanks below describing the chief complaint that you have:

- **How long** have you had the above complaints? ______________________________
- **How often** do you have the above complaints? ______________________________
- Is your pain **sharp, dull throbbing, burning, numb** and/or **achy?** ______________________________
- Is your pain worse in the **morning, evening,** and/or **after a specific activity?** ______________________________
- Have you ever experienced (check all that apply):

☐ Headaches/Migraines	☐ Colic/Reflux	☐ Ear Infections	☐ Growing Pains
☐ Dizziness	☐ Poor Appetite	☐ Asthma	☐ Female/Male Problems
☐ Fainting/Seizures	☐ Sugar Cravings	☐ Allergies	☐ Behavioral Problems
☐ Neck Pain	☐ Digestive Disorders	☐ Frequent Colds	☐ ADD / ADHD
☐ Low Back Pain	☐ Stomach Aches	☐ Sinus Troubles	☐ Bedwetting
☐ Leg/Foot Pain	☐ Constipation/Diarrhea	☐ Heart Problems	☐ Other __________

- Anything else we need to know about your health? ______________________________

Have you ever been to a chiropractor before? Yes ✐ No ✐ Date of last chiropractic visit: ___________

Are other family members under chiropractic care? Yes ✐ No ✐ Who? ___________

The vast majority of our patients have experienced dozens of falls or impacts (sports/hobby/work related) that could cause Vertebral Subluxations. Help us discover a few of yours.

✐ Which of the following sports have you been involved in? Football ✐ Basketball ✐ Soccer ✐ Running ✐ Gymnastics/Cheerleading ✐ Martial Arts ✐ Other ✐ ___________

✐ Have you ever ....Fallen down the stairs ✐ Slipped/Fell on the ground (or ice) ✐ Had a sports injury ✐ Broken a bone ✐ If so, which one: ___________

✐ Have you been involved in any car accidents/fender benders? Yes ✐ No ✐ Date ___________

Name of Family Doctor/Pediatrician : ___________

Have you ever been seen on an emergency basis? Yes ✐ No ✐ Reason/Date: ___________

Exercise: None ✐ 1-3x week ✐ 4-7x week ✐ Only PE ✐ Sports ✐ Other: ___________

Please list any past surgeries (or traumas) and dates: ___________

How many hours of sleep do you get? ___________ Do you have trouble falling asleep? ___________

Do you sleep on your stomach? ___________

Please list number of doses of antibiotics you have taken:

During the past 6 months: ___________ During your lifetime: ___________

Please list name and number of doses of any medications (prescription or OTC) taken:

During the past 6 months: ___________ During your lifetime: ___________

Please list all medications you take or have taken: ___________

Please list any vitamins/supplements you are taking: ___________

Vaccination history: ___________ Any reaction to them? ___________

Do you consume (check all that apply): Soda ______ White Flour products ______ Fast Foods ______ Fried Foods ______ Sweets ______ Dairy/Milk products ______ Meat/Fish ______

Do you have any food allergies (please list them): ___________

Location of Birth: Home ____ Birthing Center ____ Hospital (CNM or OB?) ___________

Please list any complications during pregnancy/delivery: ___________

Medications during pregnancy/delivery : ___________ Number of ultrasounds during pregnancy: ______

Birth intervention: Forceps _____ Vacuum _____ Caesarian: planned or emergency: ___________

How long were you breastfed? ___________ Were all developmental milestones met on time? ___________

I agree to assume responsibility for any charges created/incurred by the chiropractic care, and give consent for my child to be examined and/or treated by Dr. Wallin and/or his staff. I hereby authorize assignment of my insurance rights and benefits (if applicable to the provider for services rendered).

Parental Signature ___________________________ **Date** ___________