Patient Information

Date:_____

Last Name: _____

First Name:_____Prefer:_____

Middle Initial:_____

Address:_____

City:_____ State:_____ Zip:_____

Birth Date:_____

Father Name:_____

Father Birth Date:_____

Cell Phone: (_____)_____

Mother Name:_____

Mother Birth Date:_____

Cell Phone: (_____)_____

How did you hear about us?_____

Who can we thank for referring you?_____

Primary Care Physician:_____

PCP Phone Number: (_____) _____

Financial Agreement

Who is responsible for this account?_____

Relationship to Patient:_____

Insurance Company:_____

Group#:_____

ID#:_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscribers Name:_____

Relationship to Patient:_____

Insurance Company:_____

Group#:_____

ID#:_____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above Insurance Company(ies) and assign directly to *Dr. Maillette* all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named Doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Sign:_____

Print:_____

Date:_____

Contact Information

Appointment Reminders

Cell Carrier (Ex: Sprint/Verizon):_____

Email:_____

Which do you prefer: ☐ Text ☐ Email

Accept Text messages? ☐ Yes ☐ No

Would you like electronic appointment reminders? ☐ Yes ☐ No

IN CASE OF EMERGENCY CONTACT:

Name:_____

Relationship;_____

PhoneNumber:(_____)_____

Current Condition Information

Current symptoms?_____

When did this condition begin?_____

Is the condition due to an accident? ☐ Yes ☐ No

Date:_____

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp

☐ Other:_____

Attorney Name (If applicable):_____

MAILLETTE
FAMILY CHIROPRACTIC

Pediatric Chiropractic Health History

Please take a few moments to fill out your child's chiropractic health history. This will help us determine the type of care your child may need in order to improve their health.

Reason for seeking care:

☐Wellness Check/Spinal Check-Up

☐Specific Health Concern:_____.

Prenatal History:

Duration of Pregnancy:_____

Check any pregnancy complications:

☐Gestational Diabetes

☐Premature Labor

☐Infection

Nutrition:

☐Breastfed

☐Bottle Fed

☐Soy Based Formula

☐Cow's Milk (Age given _____)

Age solids introduced _____

Food Allergies: _____

Medications:_____

Birth Process:

Type of Birth:

☐Hospital with doctor

☐Hospital with midwife

☐Home birth with midwife

Length of delivery:_____

Check any that apply:

☐Labor induced

☐Artificial rupture of membranes

☐Cesarean delivery

☐Forceps or vacuum

☐Bruising/birth related injuries

☐Epidural given

☐CDC recommended Vaccination Schedule

☐Delayed Vaccination Schedule

☐Child not Vaccinated

Please check any problems present at birth:

☐Jaundice

☐Cyanosis

☐Difficulty breathing

☐Difficulty sucking

☐Difficulty latching

☐Other:_____

Growth and Development:

Sleeping preference/position as an infant:_____

_____

Age of Developmental Milestones (in months):

Lifted Head _____ Rolled over_____

Cooed/Laughed _____ Sat up_____

Crawled_____ Stood up_____

Walked_____ Finger fed_____

Drank from cup _____ First word_____

Has your child experienced any major falls or traumatic injuries (I.e fall from furniture or crib, hit head on floor)?

☐Yes ☐No If yes, explain:_____

Has your child ever experienced or been diagnosed with any of the following? (Check any/all that apply)

☐ADD

☐ADHD

☐Asthma

☐Headache

☐Trouble Sleeping

☐Weight Loss/ Gain

☐Ear Infections

☐Painful Urination

☐Frequent urination

☐Frequent colds

☐Sinus problems

☐Wheezing

☐Chronic Diaper Rash

☐Coordination issues

☐Persistent cough

☐Constipation

☐Stomach Ache

☐Diarrhea

☐Vomiting

☐Blood in stool

☐Bed Wetting

☐Vision Problems

☐Loss of appetite

☐Posture problems

☐Muscle/Joint pain

☐Broken bones

☐Difficulty Breathing

☐Difficulty Hearing