340.227.6409
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suite 206, St Thomas VI

CHILD'S PERSONAL INFORMATION

Today's Date_____
Child's Name _____Parent/Guardian Name_____
Child's Birthdate _____ Gender ❑ M ❑ F Number of Siblings _____
Address _____
City _____ State _____ Zip _____
Parent/Guardian Number _____ Email Address _____
Parent's occupation? _____ Employer:_____
Have your child seen a chiropractor before? ❑ No ❑ Yes, Who? (most recent)_____
Social Security Number _____-_____-_____ Height: _____. Weight: _____
Are you as the parent: ❑ Military ❑ Veteran ❑ Military/Veteran Spouse ❑ N/A
How did you hear about us? ❑ Facebook ❑ Google Search ❑ Referred by_____ ❑ Other _____
Insurance Payer: _____ Insurance Plan Name: _____
ID/Policy Number: _____ Group Number: _____

PLEASE TEXT FRONT AND BACK OF YOUR INSURANCE CARD TO OUR OFFICE ASAP
SO WE CAN VERIFY PRIOR TO YOUR FIRST APPOINTMENT: 340.227.6409

CHILD'S VISIT REASON

CHIEF COMPLAINT

1. _____
How long has this been an issue? _____ From 1-10, with 10 being the worst, how would you rate this issue? _____
How did this begin? _____
How often do they feel it? ❑ Constantly ❑ Frequently ❑ Intermittently ❑ Occasionally ❑ Daily ❑ Weekly
What does the pain feel like? ❑ Aching ❑ Throbbing ❑ Sharp ❑ Shooting ❑ Numb ❑Tingling
Since the onset, it has: ❑ Stayed the same ❑ Gotten better ❑ Gotten worse

- **Does their condition affect: ❑ Sleep ❑ Daily Routine ❑ Sitting ❑ Bending ❑ Lifting ❑Other:_____**
- **How long can they do above before they are in pain or restricted? _____ sec / min / hour**
- Does it radiate anywhere? ❑ No ❑ Yes (where?): _____
- What makes it better? _____ ❑ Nothing
- What makes it worse?_____ ❑ Nothing
- Have they had this issue treated before? ❑ No ❑ Yes
  - If Yes, What type of treatments?_____Result? ❑ Same ❑ Better ❑ Worse ❑Other_____

OTHER COMPLAINTS

2. _____
How long has this been an issue? _____ From 1-10, with 10 being the worst, how would you rate this issue? _____
How did this begin? _____
How often do they feel it? ❑ Constantly ❑ Frequently ❑ Intermittently ❑ Occasionally ❑ Daily ❑ Weekly
What does the pain feel like? ❑ Aching ❑ Throbbing ❑ Sharp ❑ Shooting ❑ Numb ❑Tingling
Since the onset, it has: ❑ Stayed the same ❑ Gotten better ❑ Gotten worse

- **Does their condition affect: ❑ Sleep ❑ Daily Routine ❑ Sitting ❑ Bending ❑ Lifting ❑ Other:_____**
- **How long can they do above before they are in pain or restricted? _____ sec / min / hour**
- Does it radiate anywhere? ❑ No ❑ Yes (where?): _____
- What makes it better? _____ ❑ Nothing
- What makes it worse?_____ ❑ Nothing
- Have you had this issue treated before? ❑ No ❑ Yes
  - If Yes, What type of treatments?_____Result? ❑ Same ❑ Better ❑ Worse ❑Other_____

CHILD'S BIRTHING HISTORY

WERE FORCEPS USED? ❑ NO ❑ YES

WAS VACUUM EXTRACTIONS USED? ❑ NO ❑ YES

HOW LONG WAS THE PUSHING PERIOD? _____

WAS THE CHILD A SINGLE BIRTH OR MULTIPLE? _____

AT HOW MANY WEEKS WAS THE CHILD BORN? _____ WKS.

HOW WAS THE CHILD DELIVERED? _____

HOW LONG WAS ACTIVE LABOR? _____

WHAT WAS THE FINAL APGAR SCORE? _____

WEIGHT AT BIRTH: _____LBS INCHES AT BIRTH? _____ INCHES

WHAT IS YOUR CHILD'S VACCINE STATUS? _____

OTHER THAN THE CONDITION(S) ALREADY SHARED, DO YOU HAVE ADDITIONAL HEALTH CONCERNS FOR YOUR CHILD?_____

CHILD'S HEALTH HISTORY

PLEASE CHECK THE BOX BELOW IF YOUR CHILD HAS ANY OF THE FOLLOWING

❑ Acid Reflux	❑ ADHD	❑ ADD	❑ Colic	❑ Congenital Anomalies
❑ Asperger's	❑ Autism	❑ Cerebral Palsy	❑ Difficulty Eating	❑ Down's Syndrome
❑ Difficulty Walking	❑ Ear Infection	❑ Bed Wetting	❑ Epilepsy	❑ Jaundice
❑ Febrile Convulsions	❑ Fever	❑ Headaches	❑ Inability to Thrive	❑ Lower Back Pain
❑ Seizures	❑ Sleeping Problems		❑ Torticollis	❑ Speech Difficulties
❑ Right Shoulder Pain	❑ Left Shoulder Pain		❑ Left Arm Pain	❑ Right Arm Pain
❑ Left Elbow Pain	❑ Right Elbow Pain		❑ Left Hand Pain	❑ Right Hand Pain
❑ Left Hip Pain	❑ Right Hip Pain		❑ Left Leg Pain	❑ Right Leg Pain
❑ Left Knee Pain	❑ Right Knee Pain		❑ Left Calf Pain	❑ Right Calf Pain
❑ Left Ankle Pain	❑ Right Ankle Pain		❑ Left Foot Pain	❑ Right Foot Pain

Does your child have any allergies? ❑Yes ❑No

If yes, please list the following including medications: _____

_____

Please list any over-the-counter medications your child may be currently taking: _____

_____

How often is your child physically active? ❑ Daily ❑ 3-4 x per week ❑ 1-2X per week ❑ Every couple weeks ❑ Less than every two weeks

Is your child on any kind of special diet? ❑Yes ❑No

If yes please describe:_____

How is your child's emotional health? ❑Very regulated ❑Sometimes regulated ❑Often challenged ❑Very deregulated

What is your biggest desire for your child in terms of health, wellness, vitality, and quality of life? _____

HEALTH HISTORY

Are there any relevant diseases in your child's immediate family such as cancers or heart conditions?

❑ No ❑ Yes, f yes please describe: _____

_____

HIPPA CONSENT

I agree to Serafina's Privacy Notice that has been provided to me.

❑ Yes I consent ❑ No I do not consent

MEDIA RELEASE

May we use photos or videos of your child for our social media and community education?

❑ Yes ❑ No

By checking "YES" I undersatnd my consent is voluntary and I won't receive any compensation. I waive rights to approve final content and release Serafina from liabilities related to their use.

SIGNATURE

Parent/Guardian Signature _____ ***Date*** _____

*(I agree to pay a no call, no show fee of $75 if I don't show up. Reschedules are **always** welcome.)*