Medina FAMILY CHIROPRACTIC & ACUPUNCTURE

Welcome to Medina Family Chiropractic and Acupuncture!

Please fill out this form and return it to the front desk.

Let us know if you have any questions!

Personal Information	**Date:**	
First name:	**Middle name:**	**Last name:**
Legal guardian(s):		
Preferred name:		
Address Street:		City:
	State:	Zip:
Social Security #:		
Preferred phone number:		
Email:		
Birthdate:		
How were you referred to us?		
Additional information		
Emergency contact name:		Phone:
Emergency contact relation:		
Pediatrician:		
Personal information		
Race (circle one)	American Indian or Alaska Native	Native Hawaiian or Other Pacific Island
	Asian	White
	Black or African American	Other
Ethnicity (circle one)	Not Hispanic or Latino	Declined
	Hispanic or Latino	Unknown
Preferred Language:	English	
(circle one)	Spanish	
	Other: _____	

Insurance information	**Please provide a copy of your insurance card**	
Insurance carrier:		
Name of policy holder:		**Date of birth of policy holder:**
Relationship of policy holder to you:	Self Child	Spouse
Secondary insurance carrier: (if any)		

Authorization and release: I authorize payment of insurance benefits directly to Medina Family Chiropractic. I authorize Dr. Heather Martin or Dr. Angela Hobbs to release all information necessary to communicate with personal physicians and other health care providers and mayors and to secure payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage.

Patient's name (printed): _____

Guardian's Signature: _____ Date: _____

Guardian's name: _____

*Since many insurance companies do not cover chiropractic services for children, we offer a discount program called Chiro Health USA. Please see the front desk staff for information about the discounts we offer through Chiro Health USA.

Birth History			
Delivery method: Circle all that apply	Vaginal C-section	Forceps Epidural	Vacuum extraction
Was the child in normal head down position during delivery?	No	Yes	
Please list any complications during pregnancy:			
Please list any complications during delivery:			
Are there any known congenital anomalies?	No	Yes, please describe:	

Past Health Information		
Has child had previous chiropractic care?	No	Yes Reason:
Please list any major injuries, falls, or accidents and dates:		
Please list any broken bones or dislocations and dates:		
Does your child participate in high impact or contact sports?	No	Yes Please list:
Please list any surgeries or hospitalization and dates:		

Please list all health conditions of immediate family:	
Conditions:	**Family member:**
Conditions:	**Family member:**
Conditions:	**Family member:**
Family history is unknown _____	

Current Health	
Current weight:	
Current height/ length:	
Current medications:	

Reason for today's visit	(Circle all that apply)
Wellness check	
Colic	Start date:
Reflux	Start date:
Ear infection(s)	Last ear infection:
Teething	
Sleep issues	
Constipation	Last bowel movement:
Breast feeding issues	
Respiratory infection(s)	Please describe:
Behavior issues	Please describe:
Asthma	
Allergies	
Bedwetting	How often:
Digestive issues	
Scoliosis	
Misshapen head (plagiocephaly)	
Wry neck (torticolis)	
Headaches	
Back pain	
Growing pains	
Other:	Describe:

I certify the information provided is accurate to the best of my knowledge:

Guardian Signature: _____

Guardian name printed: _____ Date: _____