Torch Chiropractic
Family Wellness Center

Today's Date

Child Name First	MI	Last
Nickname	Birth date	
Guardians names		Relationship
Address		Home Phone ( )
City/State/Zip		Cell Phone ( )

Primary Insurance Company	Policy Number
Insured's Name	
Insured's Date of Birth	

Who were you referred by or how did you hear about our office?	
Has the child been to a chiropractor?	Chiropractors' names:
When was the child's last visit?	
Please list the name and specialty of other health professionals that the child is receiving care from.	

Are you here for subluxation correction (wellness care) or symptoms?
In general, how is your child's health?
Health conditions or concerns and when symptoms began:

Check any of the following conditions that your child has had in the past year:

❒ Asthma	❒ Constipation	❒ Headaches	❒ Seizures
❒ ADD/ADHD	❒ Diarrhea	❒ Nervousness	Other:_____
❒ Bed Wetting	❒ Ear Infections	❒ Recurring Fevers	
❒ Chronic Colds	❒ Growing Pains	❒ Scoliosis	

Please list all allergies:

Has your child received vaccinations?

Has your child ever been in a car accident?
What other accidents, injuries or falls has your child experienced?
Please list all surgeries that the child has had and when:
Please list the name of any drugs or medications and the related condition.
Number of doses of antibiotics your child has been on in the past year? ___
Please list any supplements (vitamins/herbs, etc…)

What activities is your child involved in (sports, recreational activities, academic clubs…)

Other concerns regarding your child's health: