Knewtson Health Group

New Patient
Child

About Child

Name_____

Address _____

City_____State_____Zip_____

Home Phone _____

DOB_____SS#_____

Gender_____Weight_____

About Parent

Name_____

Employer _____Address_____

Type of Work _____

Work Phone_____Cell Phone_____

Marital Status _____SS#_____Driver's License#_____

E-mail Address _____

Payment Method O Cash O Check O Credit Card

Financial Responsibility

Who is responsible for payment?_____

How will you pay for your care?_____

O Cash O Check O Credit Card # _____Exp._____

Insurance Co. _____Group Policy #_____

Address_____Phone #_____

Policy Holder's Name_____Policy Holder's DOB _____

Relation _____Policy Holder's Employer_____

23505 Smithtown Road, Suite 100, Excelsior, MN 55331 952-470-8555

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Reason For This Visit

Describe the purpose of this visit._____

_____

Is the purpose of this visit related to: O Sports O Auto O Fall O Home Injury O Other
Please explain: _____
When did this condition begin?_____
Has this condition: O Worsened O Stayed Constant O Comes and Goes
Does this condition interfere with: O Sleep O Daily Routine O Other Activities
Please explain: _____
Has this condition occurred before? O Yes O No
Please explain: _____
Have you seen other doctors for this condition? O Yes O No
Doctor's Name(s):_____
Type of treatment:_____
Results: _____
Who referred you to our clinic?_____

Vaccinations

Have you chosen to vaccinate your child? O Yes O No
If yes, check all that your child has received:
O DPT O MMR O Chicken Pox O Hepatitis O Other
Describe any and all reactions to vaccine(s):_____

_____

Mother's Pregnancy & Labor

During Pregnancy: O Drugs/ Medicine O Tobacco/Alcohol
Please explain: _____
Any illness during pregnancy?_____
How was your delivery? O Labor chemically induced O Labor was doctor assisted
O C-section delivery O Forceps/Vacuum extraction O Premature delivery
O Doctor pulled or twisted baby
Please explain:_____
Did you nurse the baby? O Yes O No
Did your baby have colic? O Yes O No
Feeding problems? O Yes O No

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Child's Health History

Please check each of the diseases or conditions that your child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

O Allergies	O Breathing Problems	O Frequent Colds	O Skin Problems
O Asthma	O Colic	O Headaches	O Sleeping Problems
O Attention Problems	O Constipation	O Hyperactivity	O Tubes in the Ears
O Back Pain	O Digestive Problems	O Irritability	O Vision Problems
O Bed Wetting	O Ear Problems	O Neck Pain	O Other_____

Child's Current Health Status

Has your child ever:	No	Yes	If yes, please explain.
Taken antibiotics?	O	O	_____
Been hospitalized?	O	O	_____
Been in a car accident?	O	O	_____
Is your child accident prone?	O	O	_____
Had surgery?	O	O	_____
Had a sports related injury?	O	O	_____
Currently taking any medications?	O	O	_____
Having difficulty interacting with others?	O	O	_____

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?_____

What changes (if any) in your child's health or behavior would you like accomplished?

_____

Goals For My Child's Care

People see Chiropractor's, Physical Therapists, Massage Therapists and other health care professionals in our clinic for a variety of reasons. Some come for relief of pain, some to correct the cause of pain and other for correction of whatever is malfunctioning in their bodies. We will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

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O Relief Care – Symptomatic relief of pain and discomfort.

O Corrective Care – Correcting and relieving the cause of the problem as well as the symptoms.

O Comprehensive Care – Bring whatever is malfunctioning in the body to the highest state of health possible with our professional care.

O I want the Doctor to select the type of care appropriate for my child's condition(s).

Parent or guardian signature:_____Date_____

Child's name: _____

Authorization For Care of a Minor

I hereby authorize the doctors in this healthcare facility and whomever they may designate as their assistant to administer treatment to work with my condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this facility. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Name of parent or guardian:_____Date_____

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