Dr. Fawn Shaffer, DC
565 McElhattan Drive
Lock Haven, PA 17745
(570) 748-3590

YOUTH (6 – 18 YEARS OLD) INFORMATION: Male Female

Child's Name: _____ Nickname: _____

Age: _____ DOB: _____

Mother's Name: _____ Father's Name: _____

Address: _____ City/State/ Zip: _____

Home Phone: (_____) _____-_____ Mom's Cell Phone: (_____) _____-_____

Dad's Cell Phone: (_____) _____-_____ Email: _____

Which Phone Number is Best to Contact? ***HOME*** ***MOM*** ***DAD*** Best Time to Contact: _____

Email Address: _____ School _____ Grade: _____

Number of Siblings: _____ Names & Ages: _____

Whom May We Thank For Referring You? _____

If You Weren't Referred, How Did You Hear About Our Office? _____

INSURANCE INFORMATION:

Do you have insurance? **YES** **NO** If so, please choose: BC/BS Other_____

Policyholder's Name _____ Date of Birth _____

"It is easier to build strong children than to repair broken adults."

~ Frederick Douglass

GENERAL INFORMATION:

CURRENT WEIGHT: _____ CURRENT HEIGHT: _____

Number of Hours Sleeping per Night: _____ **Quality of Sleep**: *GOOD FAIR POOR*

Who is the child's Pediatrician? _____

Date of Last Visit? _____ **Reason?** _____

Is the child vaccinated? *YES NO*

How many times has the child been on antibiotics in the past 6 months? _____ **During his/her lifetime?** _____

PLEASE CHECK ANY OF THE FOLLOWING ISSUES THIS CHILD HAS EVER SUFFERED FROM:

	HEADACHES		BROKEN BONES
	DIZZINESS		DIGESTIVE DISORDERS
	FAINTING		POOR APPETITE
	SEIZURES/CONVULSIONS		STOMACH ACHES
	HEART TROUBLE		REFLUX
	CHRONIC EARACHES		CONSTIPATION
	SINUS TROUBLE		DIARRHEA
	ASTHMA		DIABETES
	COLDS/FLU		HYPERTENSION
	COLIC		ANEMIA
	ORTHOPEDIC PROBLEMS		BED WETTING
	NECK PROBLEMS		BEHAVIORAL PROBLEMS
	ARM PROBLEMS		ADD/ADHD
	LEG PROBLEMS		RUPTURES/HERNIA
	JOINT PROBLEMS		MUSCLE PAIN
	BACKACHES		GROWING PAINS
	POOR POSTURE		WALKING TROUBLE
	SCOLIOSIS		OTHER:

DOES THE CHILD HAVE ANY KNOWN ALLERGIES? *YES NO*

If Yes, Please List: _____

HAS THIS CHILD EVER SUSTAINED AN INJURY PLAYING ORGANIZED SPORTS? *YES NO*

IF YES, PLEASE EXPLAIN: _____

HAS THIS CHILD EVER SUSTAINED INJURIES IN AN AUTO ACCIDENT? *YES NO*

IF YES, PLEASE EXPLAIN: _____

HAS THIS CHILD HAD ANY SURGERIES? *YES NO*

IF YES, PLEASE LIST WITH DATES: _____

IS THIS CHILD ON ANY MEDICATIONS? *YES NO*

IF YES, PLEASE LIST: _____

**** WHY ARE YOU BRINGING YOUR CHILD IN FOR TODAY'S APPOINTMENT? ****

_____

_____

HAS THE CHILD SEEN A CHIROPRACTOR BEFORE? *YES NO*

IF SO, WHO? _____ DATE OF LAST VISIT? _____

DOES THE CHILD PARTICIPATE IN ANY SPORTS OR OTHER EXTRACURRICULAR ACTIVITIES? *YES NO*

IF YES, PLEASE LIST: _____

Family Health Profile:

Some health issues are hereditary. Please tell Dr. Shaffer about the health of the child's immediate family.

RELATIVE	AGE (If Living)	HEALTH (Good or Poor)	ILLNESSES	AGE AT DEATH
MOTHER				
FATHER				
SISTER 1				
SISTER 2				
BROTHER 1				
BROTHER 2				
OTHER:				

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AUTHORIZATION FOR CARE OF A MINOR

I HEREBY AUTHORIZE THIS OFFICE AND THE DOCTOR TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR GUARDIAN)

I ACKNOWLEDGE THAT ANY INSURANCE THE CHILD MAY HAVE IS AN AGREEMENT BETWEEN THE CARRIER AND THE POLICYHOLDER AND THAT I AM RESPONSIBLE FOR THE PAYMENT OF ANY COVERED AND NON-COVERED SERVICES THE CHILD RECEIVES

SIGNED: _____ **DATE:** _____

WITNESSED: _____ **DATE:** _____

Please initial your agreement to the following statements and then sign below:

_____ I instruct the chiropractor to deliver the care that, in her professional judgement, can best help the child in the restoration of his/her health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

_____ I authorize the release of any information concerning the child's health and health care services to his/her insurance companies, if applicable. If at any time I want to revoke this consent it must be done in writing.

_____ I authorize and direct payment of any and all insurance benefits allowable to the doctor as payment toward the total charges for professional services rendered. I acknowledge that any insurance the child may have is an agreement between the carrier and the child's parent/guardian and that I am ultimately responsible for the payment of any covered or non-covered services the child receives.

_____ I may request a copy of the Privacy Policy and understand it describes how the child's personal health information is protected and released on his/her behalf for seeking reimbursement from any involved third parties.

_____ I grant permission to be called to confirm, reschedule or discuss appointments and to be sent occasional cards, letters, emails or health information as an extension of the child's care in this office.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of the child's health concern.

Signature_____ **Date:** _____