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? _____

"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)

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.

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_____ 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.

_____ 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: _____