REVIVE
Chiropractic & Wellness

PATIENT APPLICATION FORM

WELCOME TO OUR CLINIC. We specialize in assisting our patients to achieve and maintain their highest level of health through spinal correction and implementing foundational lifestyle changes to improve functionality. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

_____
Patient Signature (if minor, parent signature)

_____
Today's Date:

125 Little Canada Rd W #115, Roseville, MN 55117 Ph: 651.765.1320

PEDIATRIC INTAKE & HISTORY

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PATIENT INFORMATION

Patient Name_____
Address_____
City_____State_____
Home Phone_____
Cell Phone _____
Email_____
Sex ❑ M ❑ F Age ____ Birthday_____

IN CASE OF EMERGENCY, CONTACT

Name_____
Relationship_____
Contact Number _____

Mother's Name _____
Mother's Occupation _____
Mother's Phone _____
Mother's Email _____

Father's Name _____
Father's Occupation _____
Father's Phone _____
Father's Email _____

Who may we thank for referring you?

_____

HOW CAN WE HELP YOUR CHILD?

❑ Wellness Checkup ❑ Other: _____

If your child is already experiencing a symptom, please describe it:

Has your child been treated on an emergency basis? ❑ Yes ❑ No

Please describe: _____

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

❑ Back/Other Pain ❑ Gestational Diabetes ❑ Pre/Eclampsia ❑ Strep B ❑ Nausea/Vomiting
❑ Pre-Term ❑ Fatigue ❑ Swelling ❑ Other (please describe) _____

BIRTH HISTORY

Type of birth (check all that apply):

❑ Hospital ❑ Birth Center ❑ Home ❑ Normal / Vaginal ❑ Breech
❑ Cesarean ❑ Scheduled/Induced ❑ Epidural

Problems during labor / delivery? _____

❑ Antibiotics ❑ Congenital Anomalies ❑ Failure to Thrive ❑ Jaundice ❑ Meconium
❑ Respiratory Distress ❑ Extended Hospitalization ❑ Other _____

GROWTH & DEVELOPMENT

Infant feeding: ❑ Breast ❑ Bottle ❑ Formula

Number of hours of sleep each night:_____ Quality of sleep: _____

At what age did the child:

Respond to sound: _____ Crawl: _____ Hold head up: _____

Stand: _____ Sit unsupported: _____ Walk unsupported: _____

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

❑ Chicken Pox ❑ Measles ❑ Robiola

❑ Mumps ❑ Rubella ❑ Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

❑ Allergies ❑ Broken Bones ❑ Digestive Issues (constipation/diarrhea) ❑ Hypertension ❑ Orthopedic Problems

❑ Anemia ❑ Chronic Ear Aches ❑ Juvenile / Rheumatoid Arthritis ❑ Paralysis

❑ Arm Problems ❑ Colds/Flu ❑ Dizziness ❑ Poor Appetite

❑ Asthma ❑ Colic ❑ Fainting ❑ Joint Problems ❑ Ruptures/Hernias

❑ Back Aches ❑ Convulsions/Seizures ❑ Headaches ❑ Leg Problems ❑ Sinus Trouble

❑ Bed Wetting ❑ Delayed Speech ❑ Heart Trouble ❑ Neck Problems ❑ Tuberculosis

❑ Behavioral Problems ❑ Diabetes ❑ Hyperactivity ❑ Neuritis ❑ Walking Problems

Have you vaccinated your child?

❑ No ❑ Yes ❑ As Scheduled ❑ Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

_____

_____

MEDICATIONS (list)

_____

_____

SURGERIES (list)

_____

_____

FAMILY HISTORY (list)

_____

_____

SIBLINGS

How many children do you have?_____ Number of pregnancies: _____

Children's Ages:_____ Are you currently pregnant? ❑ No ❑ Yes, I'm due: _____

Children's health concerns:_____ Health concerns regarding this pregnancy? _____

_____ _____

Authorization for Care of Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed: _____ Witnessed: _____ Date: _____

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