27850 Gratiot Avenue
Roseville, MI 48066
Phone (586) 772-5876
Fax (586) 772-1122

LUPO
CHIROPRACTIC LIFE CENTER, P.C.

# CHILD PATIENT INFORMATION CARD

Date _____ Social Security # _____

Name _____ Parent/Guardian _____
*Last* *First* *Middle Initial*

Address _____ City _____ St _____ Zip _____

Phone _____ Cell _____ E-mail _____

Date of Birth _____ Age _____ ❑ M ❑ F Ht: ___ft. ___in. Wt. _____ Referred By _____

DOES YOUR CHILD HAVE ANY **DIFFICULTY WITH ANY OF THE FOLLOWING? CHECK ALL THAT APPLY:**

| | | | |
|---|---|---|---|
| ❑ Ear Infections | ❑ Scoliosis | ❑ Fainting or Seizures | ❑ Anemia |
| ❑ Asthma | ❑ Digestive Problems | ❑ ADHD | ❑ Abdominal Pain |
| ❑ Diabetes | ❑ Bed Wetting | ❑ Car Accident | ❑ Irritability / Moodiness |
| ❑ Headaches | ❑ Sleeping Trouble | ❑ Dizziness | ❑ Diarrhea / Constipation |
| ❑ Sinus Trouble | ❑ Chronic Fatigue | ❑ Loss of Balance | ❑ Groin Pain |
| ❑ Shortness of Breath | ❑ Eye / Vision Trouble | ❑ Thyroid Trouble | ❑ Knee Pain |
| ❑ Chronic Colds | ❑ Pain in Shoulder / Arm | ❑ Heart Trouble | ❑ Leg / Foot Pain |
| ❑ Recurring Fevers | ❑ Chest or Rib Pain | ❑ Liver Trouble | ❑ Buttocks Pain |
| ❑ Temper Tantrums | ❑ Hearing Difficulties | ❑ Kidney Trouble | ❑ Hip Pain |
| ❑ Cancer | ❑ Nerves, Nervousness | ❑ Painful Menstruation | ❑ Tailbone / Sacrum Pain |
| ❑ Growing / Back Pains | ❑ Stress / Anxiety | ❑ Irregular Menstruation | ❑ Low Back Pain |
| ❑ Neck Pain | ❑ Mid Back / Shoulder Blade Pain | ❑ Upper Back Pain | ❑ Other _____ |

Other **doctors seen** for this condition _____

List all **surgeries** and when _____

List all **medications / antibiotics** and what they're for _____

**Previous chiropractic** care? ❑ Yes ❑ No When? _____ Where? _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (i.e.: a bed, changing table, down the stairs, etc). **Was this the case with your child?** ❑ Yes ❑ No

Is / has your child been involved in any **high impact or contact type sports?** (soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.) ❑ Yes ❑ No List any and all accidents, traumas or injuries and dates: _____

Has your child ever been involved in a **car accident**? ❑ Yes ❑ No _____

Has your child ever been seen on an **emergency basis**? ❑ Yes ❑ No _____

Has your child had **any of the following**:

Chicken Pox ❑ Yes ❑ No Age _____ Mumps ❑ Yes ❑ No Age _____ Whooping Cough ❑ Yes ❑ No Age _____

Rubella ❑ Yes ❑ No Age _____ Rubeola ❑ Yes ❑ No Age _____ Other _____ Age _____

**Primary / Family Doctor**: Name, address, phone _____

**Primary Insurance** _____ Subscriber's Date of Birth _____

Subscriber's Employer _____ Subscriber's SS# _____

**Secondary Insurance** _____ Subscriber's Date of Birth _____

Subscriber's Employer _____ Subscriber's SS# _____

**Authorization for Care of Minor:** I hereby authorize this office and its Doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payments of all fees charged by this office.

Parent/Guardian Signature _____ Date _____

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## CONSENT FOR CARE OF MINOR CHILD

I, _____, request and consent to the release of information for the purpose of treatment at Dr. Lupo's office **and to administer chiropractic care as deemed necessary to my child**, _____.

Parent/Guardian Signature _____ Date _____