Confidential Patient Information

Triangle CRC, PLLC
4817 Hargrove Rd. Suite 105
Raleigh, NC 27616

(919) 792-8682 Phone
(919) 882-1774 Fax
www.TriangleCRC.com

PEDIATRIC (3-10)

Date:_____/_____/_____

Patient's Full Name _____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ E-Mail: _____

☐ Male ☐ Female Date of Birth:_____/____/_____

How did you find us?

☐ Existing Patient
Name:_____
☐ Physician
Name:_____
☐ Friend
Name:_____
☐ Other_____

☐ Office Website
☐ MPI Website
☐ Doula _____
☐ Midwife_____

☐ Google:_____
☐ Social Media (i.e. Facebook)

Social Security # _____ - _____ - _____

Emergency Contact:_____ Relationship:_____ Phone: _____-_____-_____

Family Physician: _____ City: _____ State:_____ Phone_____

Previous Chiropractic Care: ☐ Yes ☐ No If Yes, for what Problem: _____

Doctor's Name __ _____ City: _____ State: _____

Authorization of Release

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me. I understand that you do not bill insurance companies directly, but I authorize the release of my information should I choose to seek reimbursement.
2. I acknowledge that my health-related information may be shared with other providers for my benefit and fully authorize you or another provider to exchange this information as necessary; this includes, but is not limited to: diagnostic imaging, patient records, and/or any pertinent health-related information.

Patient/Guardian Signature:_____ Date:_____/_____/_____

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Dear Parent/Gaurdian: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help your child. If we do not sincerely believe this child will respond satisfactorily, we will not accept your case. THANK YOU.

Present complaint(s)/concern(s):_____

When did symptoms begin? (Specific date if possible)_____

Family Doctor / Pediatrician:_____

Any known food allergies? ☐ Yes ☐ No If yes, list:_____

Typical daily/weekly diet consists of: (Circle all that apply)

Meat Vegetables Fruit Nuts Fish Eggs Sugar Dairy Grains (refined/unrefined)

Milk source: Cow 2% Cow Whole Goat Almond Coconut None

Frequency of eating: _____

Types of snacks:_____

Breastfed/Formula? How long? _____

Birth history (natural, C-section, forceps, epidural, pitocin, length of labor, etc.):_____

_____

_____

Sleep Patterns: _____

Temperament and Social Interactions: _____

Exercise Routine/Activity level: _____

History of accidents/falls/trauma: _____

_____

_____

Significant Illness/Hospitalization: _____

_____

Immunizations: (Circle one) Current Delayed None

☐ Yes ☐ No Does anyone in the household smoke?

☐ Yes ☐ No Previous chiropractic care? If yes, when/whom? _____

FAMILY HISTORY AND HEALTH STATUS: list any diseases, disorders, or major illnesses. If deceased, from what?

Mother:_____ Father:_____

Brother(s):_____ Sister(s):_____

Other:_____ Other:_____

Other health concerns?_____