

Date: ____/____/____

Patient's Full Name _____

Parent/Guardian (s) Full Name(s) _____

Mailing Address: _____ City: _____ State: _____

Zip: _____

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

Male Female Date of Birth: ____/____/____

Number of Siblings/Ages _____

| How did you find us? | | |
|--|--|--|
| <input type="checkbox"/> Existing Patient Name: _____ | <input type="checkbox"/> Office Website <input type="checkbox"/> MPI Website <input type="checkbox"/> Other Website: _____ | <input type="checkbox"/> LaCrosse Chamber <input type="checkbox"/> Google: _____ <input type="checkbox"/> Social Media (i.e. Facebook) |
| <input type="checkbox"/> Physician Name: _____ | | |
| <input type="checkbox"/> Friend Name: _____ | | |
| <input type="checkbox"/> Other _____ | | |

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: _____

Is Today's Visit Due To An Auto Accident: Yes No

(If yes, please check with receptionist, additional information is needed)

Date of Injury: _____

Authorization and Assignment

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

- 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 authorize my attorney and/or any insurance company to make **direct payment to you** of settlement proceeds.
- I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, **I personally owe to you.**
- I further agree that this Authorization and Assignment is irrevocable until all moneys owed to you (Coulee Health, Spine and Bodyworks, LLC) are **paid in full.**

Parent/Guardian Signature: _____ **Date:** ____/____/____

Dear Parent/Guardian: 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.

Pregnancy & Birth

Birth Weight _____ Birth Length _____ Age of Mother @ baby's birth _____

Infant's gestational age: Full Term Preterm If so, # of weeks _____ Post-term

Apgar scores (if known) _____

Type of Delivery: Vaginal C-section If so, please explain in space provided below.

Initial feeding of baby: Breast Bottle If bottle, was breast feeding attempted Yes No

Name of Midwife or Obstetrician / Place of birth / City / State _____

Did mother take any supplements or herbal remedies during pregnancy? Yes

No

If yes, explain

Did mother use cigarettes, alcohol, recreational drugs or prescription medications during this pregnancy? Yes

No

If yes, explain

Were there any complications with the pregnancy (i.e., diabetes, infections, high blood pressure, breech presentation, preterm labor)? Yes No

If yes, explain

Were there any problems/complications during labor? Yes No

No

If yes, explain

Were there any problems/complications with mother or baby postpartum? Yes No

No

If yes, explain

In the space below please explain in further detail any of the above information, as needed:
