Khalsa Chiropractic

5880 San Vicente Blvd, Suite 101, Los Angeles, CA 90019 · Phone (323) 857-1277 · Fax (323) 857-1574

Child's Confidential Patient Information

Please fill out this form and bring it to your visit. You can type into it on a computer and then print it, or print it and fill it out by hand. If you need help with this form, call us at (323) 857-1277.

Today's date

About the child

Child's full name

Age	Birth date

Street address

City	State	ZIP code

Parent/Guardian 1

Name	Relationship to child

Cell phone	Home phone	Work phone

Street address

City	State	ZIP code

Employer	Employer's address

Parent/Guardian 2

Fill out this section if there is a second parent or guardian.

Name	Relationship to child

Cell phone	Home phone	Work phone

Street address

City	State	ZIP code

Employer	Employer's address

Insurance and referral

Name of insured	Insurance company

Who referred you to our office?

Reason for this visit

Has the child ever been under chiropractic care? ◯Yes ◯No	Chiropractor's name

Present reason for consulting the office:

◯Chiropractic checkup and spinal examination ◯Specific symptom or condition

Date symptoms appeared or accident happened

Has the child had the same or a similar condition before?

◯Yes ◯No

If yes, when? Please describe.

Purpose of this appointment (including major complaint, if any)

What activities aggravate this condition?

Is this condition:

◯ Getting worse ◯ Getting better ◯ Staying the same

Is this condition interfering with:

☐ School ☐ Sleep ☐ Daily routine ☐ Other activities:

Other doctors seen for this condition

Health history

Name of pediatrician	**Pediatrician's address**

Date of last physical exam

Surgeries, serious illnesses or accidents (include dates)

Medications the child is taking

Vitamins or supplements the child is taking

Has the child suffered from any of these?

For each one, choose how often.

Condition	Never	Rarely	Occasionally	Frequently
Allergies	◯	◯	◯	◯
Asthma	◯	◯	◯	◯
Headache	◯	◯	◯	◯
Sleeplessness	◯	◯	◯	◯
Dizziness	◯	◯	◯	◯
Fatigue or listlessness	◯	◯	◯	◯
Nervousness	◯	◯	◯	◯
Depression	◯	◯	◯	◯
Neck pain or stiffness	◯	◯	◯	◯
Low back pain	◯	◯	◯	◯

Condition	Never	Rarely	Occasionally	Frequently
Foot trouble	◯	◯	◯	◯
Sinus infections	◯	◯	◯	◯
Ear aches	◯	◯	◯	◯
Bed-wetting	◯	◯	◯	◯
Digestive problems	◯	◯	◯	◯
Nausea	◯	◯	◯	◯
Tonsillitis	◯	◯	◯	◯
Colds	◯	◯	◯	◯
Bronchitis	◯	◯	◯	◯
Nosebleeds	◯	◯	◯	◯
Hyperactivity	◯	◯	◯	◯
Leg pains	◯	◯	◯	◯
Arm or shoulder pains	◯	◯	◯	◯
Growing pains	◯	◯	◯	◯
Limping	◯	◯	◯	◯
Fevers	◯	◯	◯	◯

Other information

Remarks and additional information

Payment and consent

Name of person responsible for payment

Is the child insured?	If yes, insurance company
◯Yes ◯No	

I hereby authorize treatment of my child in this office.

Please sign by hand after printing.

Signature of parent or legal guardian	Date