

Welcome to Trillium Health & Wellness, S.C.

Patient Information

Date:

Patient Name (Legal):	Preferred Name:	
Address:		
City:	State:	Zip:
Birth Date:	Age:	Male / Female
Parents:		
How did you find out about Trillium?		
Have the patient ever been to a Chiropractor before?		
If yes, what doctor and what for?		

Authorization to Treat a Minor

I, the undersigned hereby attest and warrant that I am the legal guardian of: _____,
(Minor Patient's Name)

a minor child as described by law, and, I warrant that my authority to act of the child's behalf is by virtue of:

Being the child's natural parent

Having been duly appointed legal guardian by a Court of Competent Jurisdiction (A copy of the order is attached hereto)

and that I hereby give my consent to such medical examinations, diagnostic procedures, and treatments as may be deemed necessary by the physician for the evaluation and treatment of the condition for which this minor child has been presented. Signed in the presence of this witness on (date) _____, 20____.

Signature Parent/Guardian

Witness

The BEST way to reach me is (circle one):
Home Child's cell Parent's work Parent's cell

Home Phone: (_____) _____ - _____

- OK to leave a message with detailed information
- Leave message with contact number only

Parent's Work Phone:

- (_____) _____ - _____
- OK to leave a message with detailed information
 - Leave message with contact number only

Child's Cell Phone (if applicable):

- (_____) _____ - _____
- OK to leave a message with detailed information
 - Leave message with contact number only

Parent's Cell Phone:

- (_____) _____ - _____
- OK to leave a message with detailed information
 - Leave message with contact number only

E-mail: _____

Primary Care Doctor

Doctor's Name / Practice: _____

Address: _____

Phone: _____

Fax: _____

Family History: Note any diseases that **the patient's relatives** have had (if known):

	Arthritis	Cancer	Diabetes	Heart Disease	Stroke	Neurological	Thyroid
Father							
Mother							
Brothers/Sister							
Grandparents							

Review of Systems: Please write in a number:

1. PRESENTLY HAVE 2. PREVIOUSLY HAD 3. RELATED TO ACCIDENT

General

- Seizures
- Dizziness
- Fainting
- Headache
- Weight loss/gain
- Anxiety
- Depression
- Persistent fever

Skin:

- Acne
- Eczema
- Rash
- Changes in mole or freckle

NeuroMusculoskeletal

- Pain or stiffness in a joint:

Genito-Urinary

- Frequent urination
- Painful urination
- Bladder infection
- Hernia

Ears, Nose, Throat

- Allergy
- Asthma
- Colds
- Ear infection

Respiratory

- Chronic cough
- Difficulty breathing
- Wheezing
- Bronchitis

Cardiovascular

- Congenital heart defect
- Murmur

Gastrointestinal

- Constipation
- Diarrhea
- Distention of abdomen
- Pain over stomach
- Poor appetite
- Vomiting

Other: *(Please describe)*

Injuries/Surgeries: Please include any or all falls, head injuries, **broken bones**, dislocations, motor vehicle collisions, **surgeries**, hospitalizations, or **major illnesses**

Description

Date

Date of patient's last physical exam / check-up: ____/____ Results: _____

Allergies (medication, food, environmental, other substance): Please list and state the reaction experienced:

Patient Name: _____

Date: _____

Current Medication or Supplements: Please list the name, reason, and dosages, if possible. (Include all vitamins, herbal supplements, prescription and over-the-counter medications.)

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Social History

Activities: TV or Video Games: _____ (hours per day or week)

Sports: _____

Play: _____

Diet: *Please describe the patient's typical meals*

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Girls Only:

___ Periods have not yet started

Age periods started: _____

Date of last period: ___/___/___

Frequency: ___ days (between the start of each period) Regular? Yes No

Length: ___ days (number of days bleeding lasts)

Difficulty with Periods? Yes No Describe: _____

DOCTOR ONLY: _____

Patient Name: _____ Date: _____