

Lakefront Chiropractic Wellness Center
630 Vernon Avenue, Suites F and H
Glencoe, IL 60022
Warren Bruhl, DC, DICCP
Diplomate International Council Chiropractic Pediatrics
Pediatric Chiropractic History

Our practice specializes in the care and detection of vertebral subluxation. Vertebral subluxation is one of the most common conditions in which people suffer with and often it goes undetected for years. Vertebral subluxation refers to the condition when the spinal column is mis-aligned and causing nerve pressure or irritation. Vertebral subluxation causes dis-ease, weakened immune function, and spinal decay. Vertebral subluxation can begin with the birth process and occur as a result of daily childhood trauma such as everyday slips and falls.

Please answer these questions thoroughly so that we assist you in determining if your child have vertebral subluxation.

Child's Name _____ Nick Name _____ Date _____

Mother's Name _____ Father's Name _____

Mother's Work Phone _____ Father's Work Phone _____

Address _____ City _____ State _____ Zip _____ Home Ph. _____

E mail Address _____ Fax No. _____

Date of Birth _____ Age _____ M _____ F _____ Child's SS# _____

Who is responsible for this account? _____ Referred by _____

PLEASE ANSWER AS ACCURATELY AS POSSIBLE. THANK YOU FOR YOUR TIME IN ANSWERING THESE IMPORTANT QUESTIONS ABOUT YOUR CHILD'S HEALTH.

Has your child ever been a passenger in an automobile accident?	Yes _____	No _____
Has your child ever fallen down stairs	Yes _____	No _____
Has your child ever fallen while skiing?	Yes _____	No _____
Has your child ever been hit by a swing or fallen off a play set?	Yes _____	No _____
Has your child ever fallen off a bicycle?	Yes _____	No _____
Has your child required stitches?	Yes _____	No _____
Has your child ever fallen on ice or concrete?	Yes _____	No _____
Did your require more than one hour of pushing during your child last Stage of labor with your child ?	Yes _____	No _____
Was a forceps or a vacuum extraction device used in labor?	Yes _____	No _____
Does your child have poor coordination?		

PEDIATRIC CHEMICAL STRESSORS

Does your child take prescription medication? Yes _____ No _____

How many medications is your child currently taking? _____ 1- 3 _____ 3 -5 _____ > 5

Does your child eat processed foods (junk food)? Yes _____ No _____

Does your child eat foods with preservatives? Yes _____ No _____

Did your child require antibiotic treatment in the past? Yes _____ No _____

How many prescriptions of antibiotics has your child had in his/her lifetime?
 _____ < 5 prescriptions _____ 5 - 15 prescriptions _____ > 15 prescriptions
 _____ >20 prescriptions

Has your child taken steroids or cortisone in the past? Yes _____ No _____

Does your child have cravings for sugar? Yes _____ No _____

PEDIATRIC WELLNESS HEALTH HABITS

Does your child take vitamins? Yes No

Is your child breastfeeding or did he/she Yes No

Has your child had regular chiropractic evaluations since birth? Yes No

Are you interested in wellness care for your child? Yes No

What is your reason for your chiropractic appointment today? Please check the answer, which best describes why you consulted our practice today.

I am interested in chiropractic wellness care and I want my child to be evaluated for vertebral subluxation.

YES NO

My child has a symptom (pain) or problem that, I believe may be a chiropractic problem and related to vertebral subluxation and nerve pressure in his/her spine

YES NO

What is your child's complaint? _____

Payment Agreement

In order to keep health care cost reasonable and provide our patients with highest level of healing service we cannot offer billing service, which would require our practice to hold excess accounts overdue. Therefore, we ask you to honor your payment agreements with our practice so we can help transform the health and quality of the families we serve. Should you carry a balance past 45 days, we would like the permission to receive payment from your credit card. Please help us in our mission by providing the information below:

I agree to pay Lakefront Chiropractic at the time of service for all services that I receive. Should I accrue a past due account over 45 days, Lakefront Chiropractic Center is instructed to charge my credit card for these services.

Credit Card # _____ Card Type _____ Exp. _____
Dated at Lakefront Chiropractic Center, P.C. this _____ day of _____ 19/20 _____.

Patient _____

Witness _____