TRULL CHIROPRACTIC, P.A. 1739 Dale Earnhardt Blvd, Kannapolis, NC 28083 (704) 938-1141

Date: _____

First name: _____ Middle name: _____

Maiden name: _____ Last name: _____

Suffix: _____ Name you wish to go by: _____

Address: _____

City: _____ State: _____ Zip code: _____

Birthdate: _____/_____/_____

Sex: ❑ Male ❑ Female

How did you hear about us? _____ Who referred you? _____

Mother's Full Name: _____ Birth date: _____

Address (if different from above): _____

Cell Phone: _____ Home Phone: _____ Is the child's mother a patient? ❑ Yes ❑ No

Father's Full Name: _____ Birth date: _____

Address (if different from above): _____

Cell Phone: _____ Home Phone: _____ Is the child's father a patient? ❑ Yes ❑ No

Marital status of parents: _____ Child lives with/custody: _____

Any family or custody circumstances that we should be aware of: _____

Name(s) of step-parents, if any: _____

Emergency contact's full name: _____

Relationship: _____ Phone number: _____

I hereby grant permission for my child to receive chiropractic evaluation and treatment. I also accept full responsibility for the charges incurred during his/her course of treatment. In the event I (or the child's other parent or legal guardian) am unable to accompany my child on a future visit, I grant the following person(s) to bring my son/daughter in for treatment:

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Signature: _____ Relationship to child: _____

Date: _____ Witnessed: _____

PLEASE FILL OUT BOTH SIDES COMPLETELY.

List ALL current medications:	**Why was this prescribed?**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

** Please note: Failure to list medications will result in our office reporting "NO MEDICATIONS for this patient."

Has any doctor diagnosed you with high blood pressure/hypertension presently?

❑ Yes ❑ No

Has any doctor diagnosed you with Diabetes presently?

❑ Yes (❑ Type I ❑ Type II) ❑ No

Are you currently pregnant?

❑ Yes (Due date: _____/_____/_____) ❑ No

Have you ever had a surgery?

❑ Yes ❑ No

If yes, please list: _____

Have you ever had a fracture/broken bone?

❑ Yes ❑ No

If yes, please list: _____

Have you ever been in an accident? (auto accident or fall)

❑ Yes ❑ No

If yes, please list: _____

Signature of Parent/guardian: _____

Printed name of person above: _____

TO BE PERFORMED BY CLINIC STAFF: **HT** _____inches **WT** _____pounds **BP** _____ / _____ R / L

PLEASE FILL OUT BOTH SIDES COMPLETELY.