New Patient History
(Child / Minor)

Name: _____ Date: _____

Address: _____ City: _____ State: ____ Zip: _____

Telephone: (home)_____

Birthday: _____

Social Security #: _____ (This is required for insurance purposes only)

1. List present complaints and describe fully: _____

_____

_____

3. Duration of present condition: _____ What do you think caused condition? _____
4. Date of last adjustment? _____ Date of last physical? _____
5. Describe any falls, surgery and/or accidents that have occurred (known accidents)? _____

_____

_____

6. What medications or drugs are you currently taking? _____
7. Is there any other information that Dr. Russ Fowler should know regarding your current condition?

_____

8. Please select any of the following conditions that you have been diagnosed with or treated for:

□ Broken/Fractured Bones	□ Circulatory Problems	□ Arthritis	□ Seizures/Convulsions
□ Excessive Bleeding	□ High/Low Blood Pressure	□ Diabetes	□ Congenital Disease

9. Please select any symptoms that you now have or have had in the past:

□ Dizziness/Fainting	□ Insomnia	□ Tension	□ Confusion
□ Fatigue	□ Ulcers	□ Vision Problems	□ Hearing Problems
□ Difficulty Breathing	□ Heart Problems	□ Bladder Problems	□ Constipation
□ Diarrhea	□ Digestion Problems	□ Nausea	□ Anxiety
□ Depression	□ Irritability	□ Colic (Infants)	□ Ear Infections

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.
I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Guardian Signature: _____ Date: _____

Printed Name: _____ Relation: _____