WELLESLEY CHIROPRACTIC OFFICE
Martin G. Rosen, D.C. Erin J. Rosen, D.C. Nancy J. Watson, D.C.

Minor's Case History

PLEASE PRINT CLEARLY

Today's Date (mm/dd/yyyy)			
Patient First Name	Patient Middle Name	Patient Last Name	
Name by which she/he likes to be called	Parents' Names		
Street Address			Apt/Suite
City	State	Zip/Postal Code	Country
Mobile Phone ( )	Home Phone ( )	Work Phone ( )	
Email Address			
Birth Date (mm/dd/yyyy)	Age	Sex	Social Security Number _____ - _____ - _____
Who referred you here?	Relationship to you		

The purpose of Chiropractic care is to remove vertebral subluxations to restore normal function to the nervous system and allow your body to express its optimum potential

What is your reason for coming to our office?	
Has your child had any previous treatment? (describe)	
Outcome of treatment	
Has your child seen a chiropractor before? **YES NO** Who?	When?
How long was he/she under care?	Reason for stopping care

471 Washington Street • Wellesley • Massachusetts • 02482-5935
Telephone (781) 237-6673 Fax (781) 996-4347

Has your child ever been hospitalized? **YES** **NO** If yes, when and why?
Has your child ever had surgery? **YES** **NO** If yes, when and why?
Does your child take any medications (prescription or over-the counter)? **YES** **NO** If yes, please list:
Please describe any falls, accidents or injuries your child has had
Please list any orthopedic device (orthodics, TMJ appliance, braces, heel lifts, crutches, etc.) your child is now or has ever used
Please list any significant complications during pregnancy or delivery (medications, cesarean section, forceps, etc.)
Please add anything else you feel is pertinent to your child's health

PLEASE READ AND SIGN THE STATEMENTS BELOW:

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Wellesley Chiropractic Office to administer chiropractic care to my son / daughter / ward.

Signature _____ Date _____

Relationship to patient (CIRCLE ONE): PARENT GUARDIAN

PAYMENT AND INSURANCE INFORMATION

If your child here because she/he has been involved in an accident (automobile, personal or work-related), please notify us immediately and fill out an additional accident information form.

PAYMENT IS EXPECTED AT THE TIME OF EACH VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH OUR OFFICE

I, _____ am responsible for payment and I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. I clearly understand and agree that all services rendered to me by Wellesley Chiropractic Office 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 to me will be immediately due and payable.

Signature _____ Date _____

Relationship to patient (CIRCLE ONE): PARENT GUARDIAN