104 W Redwood St Marshall, MN (507) 532-2655
134 State Highway 68 Wabasso, MN (507) 342-2000
2340 26th St, Slayton, MN 56172 (507) 836-8971
202 E 1st St, Minneota, MN 56264 (507) 872-5200
info@fixenchiro.com

## CHILD UPDATE FORM

PLEASE UPDATE YOUR RECORDS WITH ANY CHANGES THAT HAVE BEEN MADE WITHIN THE LAST YEAR

Social Security # ___ ___ ___/___ ___/ ___ ___ ___ ___

**Last Name**___________________________ **Legal First Name**____________________ **DOB:** ___/___/___

**Preferred Name**___________________**Address**:___________________________________________________

(City) (State) (Zip Code)

**Home Phone:** (____)____-______ **Cell phone:** (____)____-_______ **Work phone:** (____)____-______

**Email address:**__________________________________________________________________________

**Will an insurance company be contributing to your care? ❐No ❐Yes** *(If no, ask us about our wellness plans)*

***Primary***: __________________________________ ***Secondary***: ___________________________________

**Please list any supplements and/or vitamins you're currently taking.**

| Supplement Name | Dosage | Frequency | What is it for? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Please list any medications, prescription drugs, and pain killers you're taking.**

| Prescription Name | Dosage | Frequency | What is it for? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Do you have any allergies?**

❐No ❐Yes, If so explain

| Allergy Name | Reaction | Onset date | Additional comments |
|---|---|---|---|
| | | ___/___/____ | |
| | | ___/___/____ | |
| | | ___/___/____ | |

**Have you had any surgeries *in the past year*?**

❐No ❐Yes, If so explain

| Type of Surgery | Date | What was it for? | Any reaction? |
|---|---|---|---|
| | ___/___/____ | | ❐Yes ❐No |
| | ___/___/____ | | ❐Yes ❐No |

**Please check all that currently apply to your health.**

| | | |
|---|---|---|
| Migraines (G43) ❐/Headaches❐ | IBS(K58) ❐/Constipation❐ | ADD/ADHD (F90) ❐ |
| Scoliosis (M41) ❐ | Eating Disorder(s)___________❐ | Epilepsy (G40.9)❐ |
| Torticollis (M43.6)❐ | Colic (R10.83) ❐ | Excessive Weight Loss/Gain❐ |
| Ear Ache/Ear Infections❐ | Frequent Choking ❐ | Jaundice(P59.9<3 mo)❐ |
| Juvenile Rheumatoid Arthritis(M08.00)❐ | Asthma (J45) ❐ | Type 1 Diabetes (E10.9)❐ |
| Psoriasis(L40.9)❐ | Eczema (L21.1) ❐ | Hepatitis ❐ A(B15.9) ❐ B(B19.10) ❐ C(B19.20) |
| Bladder Problems ❐ | Sinus Infections❐ | Night Sweats ❐ |
| Kidney Problems❐ | Frequent Colds/Flu/Illness/Fevers ❐ | Night Terrors❐ |
| Bed Wetting❐ | Anxiety (F41.9)❐ | Cancer________________❐ |
| Acid Reflux (P78.83<3mo/K21.9>3mo)❐ | Depression (F41.8)❐ | Other__________________❐ |
| Nausea/Vomiting❐ | Fatigue ❐ | |
| Celiac Disease (K90.0)❐ | Austism (F84.0) ❐/Asperger's (F84.5)❐ | |

**Summary of your family history.** ***(Please check type and list whom)***

**Cancer**

❐Thyroid(C73)__________ ❐Liver(C22.9)___________ ❐Ovarian(C56.9)__________ ❐Prostate(C61)__________
❐Colon(C18.9)__________ ❐Lung(C34.90)___________ ❐Brain(C71.9)___________ ❐Skin(C43.9)__________
❐Testicular(C62.90)______ ❐Uterus(C55)_____________ ❐Pancreatic(C25.9)________ ❐Throat(C15.9)___________
❐Breast(F-C50.919/M-C50.929)__________ ❐Other__________

**Diabetes**

❐Type 1(E10.9)____________ ❐Type 2(E11.9)________________

**Heart Attack/Disease**(I25.2) ❐__________________

**Blood Pressure**

❐High(I10)________________ ❐Low(I95.0)___________________

**Scoliosis**(M41.9) ❐_____________

**Stenosis**(M48.00) ❐_____________

**Disc Disorder**

❐Thoracic/Lumbar(M51.9)____________ ❐Cervical(M50.90)_______________

**Waiver:** I have been offered a copy of Fixen Chiropractic's *HIPAA HITEC consent*, and the following person(s) have permission to any and all of my records (if applicable). ________________________________

*(signature)*______________________________________________________________ *(date* ___/___/__

**Do you want a receipt of a clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

❐Yes, I want a summary receipt even though it may be blank.

❐No, I do not want a summary receipt after every visit.

Patient Signature: ______________________________________________ Date___/___/____

***Office Use Only*** ***HT:*** ***WT:*** ***lbs*** ***BP:*** ***/*** ***O2:*** ***Pulse:***

□***Verify info in CT*** □***EHR Wizard*** □***Alert*** □***Doctor*** □***Scan***