CASE HISTORY (MINOR)

Today's Date:_____

Patient's Name _____Nickname _____

Patient's Home Address _____

City, State, Zip _____

Birth date _____ Age _____ □ Male □ Female Phone #_____

Parent A Information:

Circle: Mother/ Father/ Step-parent/ Guardian Single / Married /Separated/Divorced / Widowed

Name _____Birth date:_____

Address (if different than child)_____

Home Phone _____ Cell Phone _____Work Phone _____

Employer _____ Social Security #_____

Parent B Information:

Circle: Mother/ Father/ Step-parent/ Guardian Single / Married /Separated/Divorced / Widowed

Name _____Birth date:_____

Address (if different than child)_____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Social Security #_____

Who is responsible for this account? □Mother □Father □Other _____

Reason for this visit: _____

When did this symptoms start?_____

Current symptoms a result of: □injury/accident □ auto accident □unknown □other_____

Has your child seen anyone else for this condition? □ No □ Yes, Who? _____

What was the diagnosis? _____

Has your child been to a chiropractor before? □ No □ Yes, Who? _____

Previous medical conditions/illnesses:_____

Consent to Treatment of Minor Child: I hereby authorize Dr. McDonald and whomever he may designate as assistants to administer chiropractic care as deemed necessary to my son/daughter.

Signature of parent or guardian Date