Dr. Debra Cheeseman
Dr. John Bosch

Chiropractic
Stepping up your health
Salem Freeman

740 South Main Street
PO Box 59
Salem, SD 57058
605-425-2754

Child Information (0-12months)

Patient Information:

Name: Date:

Health Complaints:

What is your child's ***primary*** complaint?
____
____
____

Any known causes for your child's complaints?
____

History:

Delivery (circle one): **Natural** **C-section**
How long was the delivery? ______________________________

Did you or your child have any complications during the pregnancy or during delivery?
____
____
____

What was your baby's delivery weight? ______________________________
Is the baby nursed or given formula? __________________ What type of formula? ________________
Spit up is (circle one): **Normal** **Excessive**
How long is your baby sleeping at one time? ______________________________
Any position your baby likes to lie? ______________________________

Please circle all that applies to your baby.

Constipated **Diarrhea** **Gassy** **Uncomfortable** **Cranky**

Fever **Pulls at ears** **Congestion** **Other: ______________________**

Have you taken your baby to any other doctor for this condition? __________

What Doctor and what clinic? ______________________________
____
Is your child on any medication? ______________________________
Does your child have any allergies to medications? ______________________________
Any family history of any major medical issues for dad, mom or siblings? ______________________________

Any other information about your child you think is necessary: ______________________________
____

____ ***I choose to decline receipt of my clinical summary after every visit.*** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)* **An email address is required if would like to have your clinical summary:** ______________________@______________________________

PATIENT REGISTRATION FORM

Date: ___________________

Patient Contact Information

First Name			*Middle Initial*	*Last Name*	
Date of Birth	*Social Security Number*			*Sex* ☐ *Female* ☐ *Male*	*Age*
Street Address and PO Box(if you have one)					
City		*State*		*Zip Code*	
Home phone			*Work Phone*		
Cell Phone					
Email Address					
Place of Employment and Occupation					
Status(circle one) *Single *Married *Partnered *Widowed *Separated *Divorced					

1. **Preferred Language:** ______________________________
2. **Race (circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer
3. **Ethnicity (circle one):** Hispanic or Latino / Not Hispanic or Latino / Decline to answer
4. **Tobacco Status:** **NEVER:** Smoker / Chewer
   FORMERLY: Smoker / Chewer
   CURRENTLY: Smoker / Chewer

If you are currently a smoker, how often? **Light** (1-9 cig./day) **Moderate** (10-19 cig./day) **Heavy** (20-39 cig./day)

Spouse, Guardian or Emergency Contact:

Full Name and Relationship			**Address (if different)**
Home Phone	**Cell Phone (Guardian 1)**	**Cell Phone (Guardian 2)**	**Work Phones for Spouses and Guardians**
Do you want these numbers as your emergency contact? YES NO **If no please fill out the information below.**			
Full Name and Relationship			
Complete Address and Phone Numbers			

How did you hear about our office? ____