St. George Wellness Centre

Dr. Shauna Sommer, D.C.

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Child History Form

Please fill in the following information with as much detail as possible. If you require assistance, the reception staff will be happy to assist you.

Child's Name: _____ Date: _____

Parent(s) Name: _____

Siblings Names & Ages _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Home Telephone _(_____)_____-_____

Alternate Telephone _(_____)_____-_____ Date of Birth: _____

Age: _____ Referred by: _____

Has your child ever received chiropractic care? ***Yes*** ***No***

If yes, please list your child's previous Chriopractor's name and visit date:

_____

Family physician: _____

What was the date of your child's last visit? : _____

Reason for visit: _____

AUTHORIZATION FOR CARE OF A MINOR UNDER 16 YEARS OF AGE:

PARENT(S) NAMES: _____TELEPHONE: _____

I hereby authorize and consent to the chiropractic evaluation and treatment of my child.

PARENT/GUARDIAN SIGNATURE: _____DATE:_____

WITNESS SIGNATURE: _____ DATE: _____