

PRACTICE MEMBER INFORMATION

Practice Member Name: _____ Birth date: _____ Age: _____ Today's Date: _____
Mailing Address: _____ Sex: M F Email: _____
City: _____ State: _____ Zip: _____ Social Security #: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____ ext. _____
Emergency contact: _____ Their phone number: _____ ext. _____
Employer/school: _____ Occupation/student _____
Employer/school address: _____ City: _____ State: _____ Zip: _____
Marital status: Child Single Married Widowed Divorced Spouse's name: _____ Occupation: _____
Children's names & ages: _____

All charges are due when services are rendered!

Preferred Method of Payment: Cash Check Credit Card Insurance
Who besides yourself, may also be responsible for your bill: Spouse Workers Comp Auto Ins Medicare
Their name: _____ Their Birth date: _____
Their Social Security #: _____ Policy # &/or Group #: _____
Insurance Company: _____ *Give your insurance card to the front desk to copy*
Practice Member or Guardian Signature: _____ Date: _____

Who may we "Thank" for referring you to our office? _____

Previous Chiropractor/s: _____ City: _____ Last Visit: _____

Reason/s for leaving: _____

Primary MD _____ City: _____ Last visit: _____

Medical Specialists you are seeing or have seen and WHY: _____

Is the reason you are here due to: Motor vehicle accident Job injury other? _____

To who have you reported this injury to: Auto Insurance Employer Workers Comp other? _____

Attorney name if applicable: _____

Have you had chiropractic care for this injury? No Yes If yes please explain whom, where, when and the care provided: _____

Did you require post-accident hospitalization? No Yes If yes please explain whom, where, when and the care provided: _____



Glas Chiropractic

Bret B. Glas, D.C.
Pediatric and Adult Wellness Chiropractic
7213 N. Allen Rd.
Peoria, IL 61614
309-693-8448
FAX 309-693-8438
www.glaschiropractic.com
drbret@glaschiropractic.com

PEDIATRIC CASE HISTORY

Child's Name _____ Today's Date _____

Date of birth _____ Age _____ Sex: Male Female SS# _____

Address _____ City _____ State _____ Zip _____

Mom's/guardian's name _____ Dad's name _____

Phone _____ Work _____ Cell _____

Parent/guardian email _____

Weight _____ Height _____ Referred by _____

Are you here for Wellness? No Yes For particular health concerns? No Yes

Chief health concerns are _____

PRENATAL/NATAL HISTORY:

The vast majority of our patients have experienced literally dozens of impacts that could cause subluxated vertebra. What I want to do now is discover several of yours.

Complications during pregnancy? No Yes List _____

Ultrasounds during pregnancy? No Yes How many? _____

Medications, alcohol, tobacco during pregnancy? No Yes List _____

Birth intervention? Forceps Vacuum extraction C-section Induced labor

Delivery Complications? No Yes List _____

Genetic disorders or disabilities? No Yes List _____

GENERAL HISTORY:

Subluxated vertebra can cause irritation to different fibers within nerves that can affect any organ or tissue, causing conditions now or in the future.

CHECK ALL OF THE FOLLOWING THAT YOUR CHILD HAS SUFFERED:

- Recurring fevers
- Ear infections
- Scoliosis
- Seizures
- Colic
- Digestive problems
- Growing pains
- ADD/ADHD
- Headaches
- Asthma
- Temper tantrums
- Bed wetting
- Chronic colds
- Low energy
- Allergies
- Other _____

Significant family history _____

Previous chiropractor _____ Date of last visit _____ Why? _____

Are you satisfied with previous care? No Yes Why? _____

Pediatrician? _____ Date of last visit _____ Why? _____

Are you satisfied with previous care? No Yes Why? _____

Surgery? No Yes List _____

About how many times has your child been put on antibiotics? In the last 6 months? _____ Lifetime total? _____

Is your child on, or has your child been on, any psychotropic drugs (Ritalin, Adderall, Prozac, etc.)

No Previously Currently List _____

Other medications (including "over-the-counter"): No Yes List _____

Has your child been vaccinated? No Yes Any reactions? No Yes List _____

According to the National Safety Council, at least 47% of children fall head first from a high place, i.e. changing table, bed, etc.

Was this the case with your child? No Yes _____

Fell down stairs? No Yes _____

Auto accidents? No Yes _____

Contact sports? No Yes _____

Other physical traumas? No Yes _____

Emotional stress? No Yes _____

Childhood diseases? No Yes _____

Does your child eat at least 2 servings fruit and 3 veggies/day? No Yes

Does your child drink half of their body weight in ounces of water/day? No Yes

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize Dr. Bret Glas and other chiropractors of this office to provide chiropractic analysis and care for my child as they deem necessary. This authorization is to be considered attached to the "Terms of Acceptance." I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signature Parent/guardian _____ signed in Peoria, IL on _____

(Please print Parent/guardian name) _____ Witnessed by _____

Bret B. Glas, D.C.



Glas Chiropractic

Bret B. Glas, D.C.
Pediatric and Adult Wellness Chiropractic
7213 N. Allen Rd.
Peoria, IL 61614
309-693-8448
FAX 309-693-8438
www.glaschiropractic.com
drbret@glaschiropractic.com

QUIZ...ARE YOU READY TO BEGIN?

Name _____ Date _____

1. What prompted you to come here now (as opposed to a month, or a year ago), seeking chiropractic care? (Hint: Your friend who referred you, or the ad that you saw, is not the answer. I want to know why you decided to take action now.) _____

2. Have you given up on other options (drugs, surgery, etc.)? Why or why not? _____

3. What KIND OF DOCTOR are you looking for? Uncovering your previous experience with "doctors" is important so we can best help meet your health needs and goals. What I mean by this is what role would you like me to play in your recovery?

- A wizard, magician, or Houdini? Do you want someone to bug you to do what's best? A listener?
 Do you prefer a coach, someone to give you information about how to prevent this sort of thing in the future?
 Do you prefer the authoritarian type, someone to tell you what to do? Other? _____

4. Why did you choose me, as opposed to another chiropractor? _____

5. Do you have any particular fears, questions or concerns about Chiropractic? No Yes If "yes," please explain: _____

6. What are your reasons for coming here? (You may check as many as you like):

- General Health/Wellness Improve immune function Improve athletic performance
 Pain relief Decrease or eliminate drugs Decrease or eliminate disease

7. Is there anyone else (spouse/partner, etc.) part of your decision to begin chiropractic care, here and now?

- No Yes If "yes," who are you bringing to your Report of Findings? _____

8. Are you ready to do something different, to take action, to improve your current level of health, and the quality of your life?

- No Yes If "yes," when? Now Later

9. How do you think that your health, and your life, might change for the better, from coming here for chiropractic care? _____

10. Five years from now, with chiropractic care, how do you see your health? _____

Thank you for completing this quiz.

A LIFETIME OF WELLNESS!