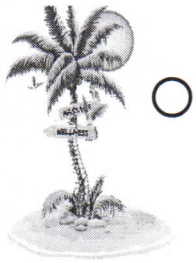


Oasis Chiropractic & *Wellness, Inc.*

8980 S Us HWY 1 Suite # 104
Port St. Lucie, FL, 34952
PH: (772) 336-8600 FAX: (772) 464-9978

Children's Health History Form

Today's Date: _____

Patient's Name: _____ DOB: _____

Gender: Male / Female Age: _____ Height: _____ Weight: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Parent A

Name: _____

Phone #: _____

Employer: _____

Email: _____

Parent B

Name: _____

Phone #: _____

Employer: _____

Email: _____

Who may we thank for referring you? _____

Reason for seeking Chiropractic Care

What concerns do you feel we can address for your child? _____

_____

Related to: ☐ Sports ☐ Auto ☐ Fall ☐ Chronic ☐ Home Injury ☐ Other: _____

Please describe how these concerns are affecting your child's quality of life.

_____

Check all that apply:

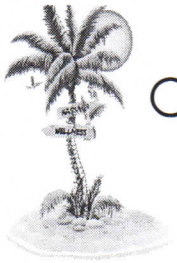
☐ School ☐ Exercise/ Sports ☐ Walking
☐ Playing ☐ Sleep ☐ Attention/Focus
☐ Communication ☐ Eating ☐ Daily Routine

Expectations of Care

I would like my child to experience the following benefits from Chiropractic Care:

Check all that apply:

☐ Symptomatic Relief of pain or discomfort
☐ Correction of the cause of the problems as well as relief of symptoms
☐ Prevention of future problems
☐ Healthier spine and nerve system
☐ Optimal health on all levels
☐ Other: _____



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Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/ or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/ or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand an am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains, I do not expect the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name: _____

Parent/ Guardian's Name: _____

Parent's Signature: _____ Date: _____