

**Gildea Holistic Health & Wellness**



**Application for Treatment of a Minor (FILL OUT ONCE)**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

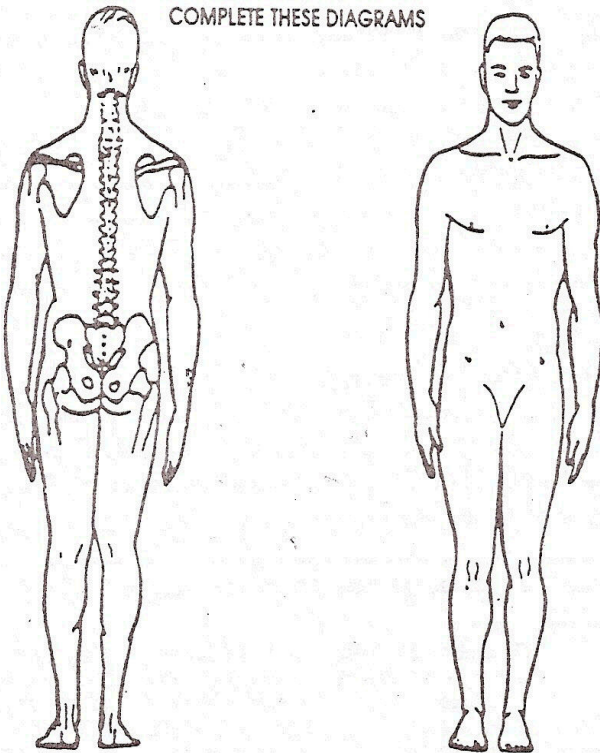
Home Phone Number: \_\_\_\_\_ Parent's Cell Number: \_\_\_\_\_

Patient's Email: \_\_\_\_\_ Family Doctor/Phone #: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Parent's Email: \_\_\_\_\_

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off & on, when standing, sitting, etc.

**MAJOR COMPLAINT**  
(Please describe only your major problem)



\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OTHER COMPLAINTS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How did this condition develop? (What caused it?)

\_\_\_\_\_  
\_\_\_\_\_

When were you first aware of this problem?

Have received any treatment for this condition? If yes, when, where and what were the results? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

ANY ACCIDENTS, FALLS, ETC THAT MIGHT HAVE CAUSED YOUR PROBLEM? \_\_\_\_\_

\_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Have you ever consulted any other Chiropractors in the past? \_\_\_\_\_ Are you Pregnant? \_\_\_\_\_

What Surgeries have been done? \_\_\_\_\_

Past and Current Health Issues \_\_\_\_\_

\_\_\_\_\_  
Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature/Parent Signature if under 18

Date