PATIENT INFORMATION

Child's Name _____ Parent(s)/Guardian(s) Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Is it okay to contact you at work? ❑ Yes ❑ No

E-mail _____ Child's Social Security # _____ Birthdate _____ Age _____

Have your or your child ever had chiropractic care before? ❑ Yes ❑ No

If yes, please tell us the doctor's name _____

Were you pleased with your care? ❑ Yes ❑ No

How did you find out about our office? _____

Is this appointment related to an auto accident? ❑ Yes ❑ No

If this injury is related to an auto accident, please fill out the Auto Accident Questionnaire.

Is your child receiving care from other health professionals? ❑ Yes ❑ No

If yes, please name them and their specialty _____

Who is your family's primary care physician? _____

Please list any drugs or medications your child is taking _____

_____

Please list any vitamins/herbs/homeopathics/other your child is taking _____

_____

Please list any allergies your child has _____

_____

CURRENT HEALTH

What health condition brings your child to our office? _____

_____

When did the symptoms first begin? _____

How did the problem start? ❑ Suddenly ❑ Gradually ❑ Post-Injury

Is this condition ❑ Getting Worse ❑ Improving ❑ Intermittent ❑ Constant ❑ Not Sure

What makes the problem better? _____

What makes the problem worse? _____

Has your child ever had a similar condition? ❑ Yes ❑ No

Please explain _____

Has your child been treated for this problem before? ❑ Yes ❑ No

Please explain _____

Does your child eat well? ❑ Yes ❑ No Does your child have regular bowel/bladder movements? ❑ Yes ❑ No

Has your child ever been checked for vertebral subluxations? ❑ Yes ❑ No ❑ Don't Know

HEALTH HISTORY

Child's birth was ❑ At home ❑ At a birthing center ❑ At a hospital

My obstetrician/midwife/family physician was _____

Child's birth was ❑ Natural vaginal (no mediciations/interventions)

❑ Vaginal with interventions

❑ Induction ❑ Pain medication ❑ Epidural ❑ Episiotomy ❑ Vacuum extraction ❑ Forceps

❑ Other _____

❑ C-section

❑ Scheduled ❑ Emergency

Please list reasons for any interventions/complications _____

_____

Child's birth weight _____ Child's birth height _____ Current weight _____ Current height _____

APGAR score at birth _____ APGAR score after 5 minutes _____

GROWTH & DEVELOPMENT

Was your child alert and responsive within 12 hours of delivery? ❑ Yes ❑ No

If no, please explain _____

At what age did the child:

Respond to sound_____ Follow an object _____ Hold head up _____ Vocalize _____

Sit alone _____ Teethe _____ Crawl _____ Walk _____

Patient/Hospitialization/Surgical history (please list below all surgeries and hospitalizations, including the year)

_____

_____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year

_____

_____

Is/was your child breastfed? ❑ Yes ❑ No If yes, how long? _____

Formula introduced at age _____ What type? _____

Introduction of cow's milk at age _____ Began solid foods at age _____

Please list any foods/juice intolerance _____

Did mother smoke during pregnancy? ❑ Yes ❑ No

Did mother drink alcohol during pregnancy? ❑ Yes ❑ No

Any illness of mother during pregnancy? ❑ Yes ❑ No

If yes, please explain including treatment/medications/supplements _____

_____

List any drugs/medications (including over the counter) taken during pregnancy _____

_____

List any supplements taken during pregnancy _____

Any exposures to ultrasound? ❑ Yes ❑ No If so, how many and what was the medical reason? _____

_____

Any pets at home? ❑ Yes ❑ No Any smokers at home? ❑ Yes ❑ No

GROWTH & DEVELOPMENT CONTINUED...

Has child received any vaccinations? ❑ Yes ❑ No

If yes, which ones and list any reactions _____

_____

Has child received any antibiotics? ❑ Yes ❑ No If yes, how many times and list reason _____

_____

Any difficulty with breastfeeding? ❑ Yes ❑ No If yes, please explain _____

_____

Any difficulty with bonding? ❑ Yes ❑ No If yes, please explain _____

_____

Any behavioral problems? ❑ Yes ❑ No If yes, please explain _____

_____

Any night terrors, sleepwalking or difficulty sleeping? ❑ Yes ❑ No If yes, please explain _____

_____

Age child began daycare _____ Average number of hours of TV per week _____

Does your child seem normal for their age? ❑ Yes ❑ No If no, please explain _____

_____

FAMILY HISTORY REVIEW

Check those involving immediate family and add identification: M=Mother; F=Father; S=Siblings; G=Grandparents

❑ Cancer, type _____
❑ M ❑ F ❑ S ❑ G

❑ Depression
❑ M ❑ F ❑ S ❑ G

❑ Diabetes
❑ M ❑ F ❑ S ❑ G

❑ Back Problems
❑ M ❑ F ❑ S ❑ G

❑ Heart Disease
❑ M ❑ F ❑ S ❑ G

❑ Liver Disease
❑ M ❑ F ❑ S ❑ G

❑ High Blood Pressure
❑ M ❑ F ❑ S ❑ G

❑ High Cholesterol
❑ M ❑ F ❑ S ❑ G

❑ Lung Problems
❑ M ❑ F ❑ S ❑ G

❑ Scoliosis
❑ M ❑ F ❑ S ❑ G

❑ Neck Problems
❑ M ❑ F ❑ S ❑ G

❑ Osteoporosis
❑ M ❑ F ❑ S ❑ G

❑ Seizures
❑ M ❑ F ❑ S ❑ G

❑ Osteoarthritis
❑ M ❑ F ❑ S ❑ G

❑ Rheumatoid Arthritis
❑ M ❑ F ❑ S ❑ G

❑ Other _____

_____

DO YOU NKOW ABOUT CHIROPRACTIC?

Do you know what a subluxation is? ❑ Yes ❑ No

Do any of your friends or relatives see a chiropractor? ❑ Yes ❑ No

If yes, do they use chiropractic for ❑ Health maintenance/optimization ❑ Health problems ❑ Both

Are you seeking chiropractic for ❑ Health maintenance/optimization ❑ Health problems ❑ Both

What would you like to gain from chiropractic care? _____

_____

Are there other health concerns or anything else you'd like us to know about your child? _____

_____