

It is our pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forwards to working with you to build better health for your family.

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parents/ Guardians \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Home Tel \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent Work Tel \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex M / F Height \_\_\_\_\_\_ Weight \_\_\_\_\_\_ # of Siblings \_\_\_\_\_\_

How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for seeking chiropractic care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other doctors seen for this condition (circle) Yes / No

If yes, doctors names and prior treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other health problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever suffered from (check all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| * Dizziness | * Backaches | * Heart trouble | * Chronic earache |
| * Diabetes | * Tuberculosis | * Hypertension | * Frequent Colds/ Flu |
| * Arthritis | * Headaches | * Asthma | * Allergies |
| * Neuritis | * Digestive Problems | * Sinus Trouble | * Constipation |
| * Anemia | * Rheumatic Fever | * Orthopedic Problems | * Diarrhea |
| * Poor Appetite | * Hyperactivity | * Paralysis | * Behavioral Problems |
| * Bed Wetting | * Convulsions | * Broken Bones | * Muscle Jerking |
| * Fainting | * Walking Problems | * Leg Problems | * Ruptures/ Hernias |
| * Neck Problems | * Arm Problems | * Colic | * “Growing Pains” |
| * Joint Problems | * Blood Disorders | * Stomach Aches | * Other \_\_\_\_\_\_\_\_\_\_\_\_\_ |

Family Health History \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Chiropractor(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you satisfied with the care your child received there? Yes / No

Name of Pediatrician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you satisfied with the care your child received there? Yes / No

Number of antibiotics you child has taken:

During the past 6 months \_\_\_\_\_\_\_\_ Total during his/her lifetime \_\_\_\_\_\_\_\_

Number of doses of other prescription medications your child has taken:

During the past 6 months \_\_\_\_\_\_\_\_ Total during his/her lifetime \_\_\_\_\_\_\_\_

Vaccination History \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRENATAL HISTORY**

Type of Birth Attendant: OB/GYN / CNM / Lay Midwife Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location of Birth: Home / Birthing Center / Hospital

Complications during pregnancy: Yes / No List \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ultrasound during pregnancy: Yes / No Number \_\_\_\_\_\_\_

Medications during pregnancy/ delivery: Yes / No List \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cigarette/ Alcohol use during pregnancy: Yes / No

Birth Intervention: Forceps / Vacuum / Caesarian Planned or Emergency? \_\_\_\_\_\_\_\_\_\_\_\_\_

Complications during delivery: Yes / No List \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Genetic disorders or disabilities: Yes / No List \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth length \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APGAR scores \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEEDING HISTORY**

Breast Fed: Yes / No How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Formula Fed: Yes / No How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Introduced to solids at \_\_\_\_\_\_\_\_ months, Cow’s milk at \_\_\_\_\_\_\_\_ months

Food/ juice allergies or intolerances: Yes / No List \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DEVELOPMENTAL HISTORY**

Number of hours sleeping per night \_\_\_\_\_\_\_\_\_\_ Quality of sleep: Good / Fair / Poor

At what age was your child able to:

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_Respond to sound | \_\_\_\_\_\_\_\_ Cross crawl |
| \_\_\_\_\_\_\_\_ Respond to visual stimuli | \_\_\_\_\_\_\_\_ Stand alone |
| \_\_\_\_\_\_\_\_ Hold head up | \_\_\_\_\_\_\_\_ Walk alone |
| \_\_\_\_\_\_\_\_ Sit up |  |

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.) Was this the case with your child? Yes / No

Is/has your child been involved in any high impact or contact type sport? Yes / No

Has your child ever been involved in a car accident? Yes / No

Other traumas not described above: Yes / No Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior surgery: Yes / No Type and Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Menarche: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHILDHOOD DISEASES**

|  |  |
| --- | --- |
| Chicken Pox Y / N Age \_\_\_\_\_\_\_ | Mumps Y / N Age \_\_\_\_\_\_\_ |
| Rubella Y / N Age \_\_\_\_\_\_\_ | Whooping Cough Y / N Age \_\_\_\_\_\_\_ |
| Rubeola Y / N Age \_\_\_\_\_\_\_ | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.**

**YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.**

**AUTHORIZATION FOR CARE OF MINOR**

I hereby authorize this office and its Doctor(s) to administer care to my Son / Daughter as they deen necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witnessed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_