

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 you 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

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 medications/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 _____

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/Hospitalization/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

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 _____

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

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Cancer, type _____
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> Depression
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> Diabetes
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> Back Problems
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G |
| <input type="checkbox"/> Heart Disease
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> Liver Disease
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> High Cholesterol
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G |
| <input type="checkbox"/> Lung Problems
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> Scoliosis
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> Neck Problems
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> Osteoporosis
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G |
| <input type="checkbox"/> Seizures
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | <input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> G | |

Other _____

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? _____