

CHILD NAME _____ DATE _____

CHILD'S DATE OF BIRTH _____ SS # _____ AGE _____

PARENT'S NAME(S) _____

SIBLING(S) NAME(S) _____

PRIMARY REASON FOR CONTACTING OFFICE: OPTIMUM HEALTH SYMPTOMS

IF SYMPTOMS:

When was this first noticed? _____

Has this ever happened before? _____ When? _____

Does this problem interfere with normal activity? _____ Explain: _____

Is there any family history of this condition? _____

List any recent falls or accidents: _____

Childbirth information:

Was the mother's labor: long _____ normal _____ short _____

If child delivered by c-section, give reasons: _____

If vaginal delivery, give presentation: head _____ breech _____ shoulder _____

Were forceps used in delivery? yes _____ no _____

Did child have any problems shortly after birth? _____

After delivery was there any trauma to the child? (such as being dropped) _____

Did the mother suffer any falls or accidents during pregnancy? _____

List any operations or hospitalizations:

_____ date: _____
_____ date: _____

List any broken bones or fractures _____

Does the child have any difficulty with the following?

N=Now P=Past O=Occasional

1. Head: _____ headaches _____ dizziness _____ sinus _____
2. Eyes: _____ glasses _____ pain _____ inflammation _____
3. Ears: _____ hearing _____ ringing _____ wax _____ pain _____
4. Nose: _____ smell _____ hayfever _____ colds _____ obstruction _____
5. Throat: _____ speech _____ pain _____ tonsils _____
6. Neck: _____ stiffness _____ pain _____ R _____ L _____
7. Shoulders: _____ stiffness _____ pain _____ R _____ L _____
8. Arms: _____ R _____ L, elbows _____ R _____ L, wrists _____ R _____ L, hands _____ R _____ L
9. Lungs: _____ frequent congestion _____ cough _____ wheezing _____
10. Abdomen: _____ stomach _____ bladder _____ soreness _____
11. Intestines: _____ digestion _____ gas _____ constipation _____
12. Kidneys: _____ bedwetting _____ burning with urination _____
13. Is the child- nervous _____ hyperactive _____ sluggish _____
14. Does the child- sleep well _____ have leg pains at night _____
15. Fainting _____ Weakness _____ Anemia _____
16. Seizures _____ Paralysis _____ Nosebleeds _____

I hereby authorize Eaton Chiropractic, to administer treatment or a spinal examination as deemed necessary to my child _____.

My relationship to this minor is _____.

Dated at _____ this _____ day of _____ 2003.

Parent Signature _____