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Today's Date: \_\_\_\_\_

Patient #: \_\_\_\_\_

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

Parent/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Subscriber Enrollment

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As an extension of the care you receive in our practice, may we add you as a subscriber to our website that will help you...

***Get Well***  
***and***  
***Stay Well.***



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First name : \_\_\_\_\_ Last name : \_\_\_\_\_

Gender :  Male  Female

Date of birth : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Email address : \_\_\_\_\_

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Naturally you can unsubscribe at any time.