695 N Perryville Rd. Ste 1
Rockford, IL 61107
815-977-5480
815-977-3479
info@healingpathrockford.com
www.healingpathrockford.com

1. **Please enter your information.**

Today's Date _____ First Name: _____ Middle Initials: _____ Last Name: _____

Date of Birth: _____ Age of patient _____ Gender: ○ Female ○ Male Parent(s) Name _____

Address: _____ Apt./Unit #: _____

Parent Mobile Phone: _____ Parent Home Phone: _____ Parent Contact Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone
○ Email

Primary Care Provider/Pediatrician _____

Insurance Carrier _____ Insured's Name (First, Last) _____

Who were you referred by? How did you hear about us?

_____

2. **Please list your top major health concerns in order of importance, and indicate date of diagnosis (where relevant):**

	Concern	Date
1		
2		
3		

3. **What is the main reason for today's visit?**

_____
_____
_____
_____

4. **Has your child seen a physician or other health practitioner about this? (medical doctor, chiropractor, etc..) If yes, when? What was the diagnosis (if any)?**

_____
_____
_____
_____

5. How long has your child had this condition?

6. Does your child experience difficulty with any of the following? You may use the boxes to further specify. Check all that apply:

- ☐ Assaults to others/self _____
- ☐ Constipation _____
- ☐ Controlling bladder _____
- ☐ Crawling _____
- ☐ Diarrhea _____
- ☐ Disobedience _____
- ☐ Feeding self _____
- ☐ Focus _____
- ☐ Hyperactivity _____
- ☐ Latching _____
- ☐ Myringotomy (ear tubes) _____
- ☐ Night terrors _____
- ☐ Poor concentration _____
- ☐ Poor immune system _____
- ☐ Posture _____
- ☐ Potty training _____
- ☐ Reflux _____
- ☐ Skin condition _ _____
- ☐ Sleeping _____
- ☐ Speaking sentences _____
- ☐ Speaking words _____
- ☐ Tolerating separation _____
- ☐ Tongue tie _____
- ☐ Unable to play cooperatively _____
- ☐ Other(s) _____

If "other(s)", please specify

7. Does your child have/had any of the following? Please use the boxes to indicate the approximate age when affected by such conditions and/or to further specify them:

- ☐ ADHD _____
- ☐ Allergies to _ _____
- ☐ Asthma _____
- ☐ Autism _____
- ☐ Cancer _ _____
- ☐ Chicken pox _____
- ☐ Chronic, serious health problems __ _____
- ☐ Ear infection _____
- ☐ Flu _____
- ☐ Fracture _ _____
- ☐ Hospitalization _ _____
- ☐ Measles _____
- ☐ Pneumonia _____
- ☐ Significant injuries __ _____
- ☐ Surgery _ _____
- ☐ Torticollis _____
- ☐ Whooping cough _____
- ☐ Other(s) _____

If "other(s)", please specify

8. **Background information**

Was your child breastfed? For how long?

If formula was introduced, at what age? What type?

What age did your child begin solid food?

Any illness of mother during pregnancy? Medication use?

Supplements mother took during pregnancy?

Has child received any vaccinations? Which ones?

How many times a year does your child get sick?

How many time has your child taken antibiotics? When?

9. **Supplements:**

	Supplement
1	
2	
3	
4	

10. **Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics) and specify the date your child started using it, how much, and why?**

	Medication	Reason for it	Dosage
1			
2			
3			
4			

11. **Do you know what a subluxation is? A subluxation is what your chiropractor removes from the spine which allows the body to communicate better therefore work better!**

- ○ Yes
- ○ No

12. **Is there anything else about your health history that you think would be useful for your practitioner to know?**

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Consent to Treatment of a Minor

I, _____, being the parent or legal guardian, hereby authorize Healing Path of Rockford's licensed chiropractic physicians, to administer treatment as deemed necessary to _____ (name of child).

Relationship to patient _____

Today's Date

_____

_____ _____

Client Signature Date