total balance
CHIROPRACTIC

Child's Name: _____DOB: _____

Age: _____ ○ Male ○ Female Number of Siblings: _____ SS#: _____

Mother's Name: _____DOB: _____

Father's Name: _____DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mother's Work Phone: _____ Mother's Cell: _____

Email address: _____ Father's Work Phone: _____ Father's Cell:_____

Purpose of this Appointment: _____

Insurance/Billing Information: _____ Policy #: _____

Referred by: _____

Pediatric History

Birth Weight: _____ Birth Length: _____ Current Weight: _____ Current Length: _____

Third Trimester Presentation: ○ Vertex ○ Breech ○ Transverse ○ Face/Brow

Type of Birth: ○ Normal Vaginal ○ Forceps ○ Cesarean ○ Suction Cap or Vacuum

Location: ○ Home ○ Birthing Center ○ Hospital

Problems During Pregnancy: _____

Problems During Labor/Delivery: _____

Apgar Scores: _____ _____ Was there presence at birth of: ○ Jaundice (Yellow)? ○ Cyanosis (Blue)?

Congenital Anomilies/Defects? ○ Yes ○ No If yes, please explain: _____

Delivery/Birth History: _____

_____

_____

Infant Feeding: ○ Breast ○ Bottle If Bottle, Which Formula? _____

Number of Hours Sleeping Per Night: _____ Quality of Sleep: ○ Good ○ Fair ○ Poor

Obstertritian/Midwife: _____

Pediatrician/Family MD: _____

Date of Last Visit: _____ Purpose: _____

Immunization History: _____

Number of doses of antibiotics your child has taken: During the past six months: _____ During his/her lifetime: _____

Previous Chiropractor: _____

Date of Last Visit: _____ Purpose: _____

Has your child ever been treated on an emergency basis? ○ Yes ○ No If yes, please explain: _____

_____

At what age did the child:

Respond to Sound _____ Follow an Object with His/Her Eyes _____ Hold head up _____

Sit alone _____ Crawl _____ Stand _____ Walk alone _____

At what age, if ever, did this child suffer from the following childhood diseases?

Chickenpox _____ Mumps _____ Measles _____ Rubella _____

Rubeola _____ Whooping Cough _____ ○ Other _____

Has this child ever suffered from: (check all that apply)

○ Headaches	○ Orthopedic Problems	○ Digestive Disorders	○ Behavioral Problems
○ Dizziness	○ Neck Problems	○ Poor Appetite	○ ADD/ADHD
○ Fainting	○ Arm Problems	○ Stomach Aches	○ Ruptures/Hernia
○ Seizures/ Convulsions	○ Leg Problems	○ Reflux	○ Muscle Pain
○ Heart Trouble	○ Joint Problems	○ Constipation	○ Growing Pains
○ Chronic Earaches	○ Backaches	○ Diarrhea	○ Allergies to:
○ Sinus Trouble	○ Poor Posture	○ Diabetes	_____
○ Asthma	○ Scoliosis	○ Hypertension	_____
○ Colds/Flus	○ Walking Trouble	○ Anemia	○ Other _____
○ Colic	○ Broken Bones	○ Bed Wetting	○ Other _____

Has this child ever suffered the following spinal traumas? (check all that apply)

○ Fall In Baby Walker	○ Fall From Bed or Couch	○ Fall Off Skateboard or Skates
○ Fall From Crib	○ Fall Off Swing	○ Fall Off Bicycle
○ Fall From Highchair	○ Fall Off Slide	○ Fall Down Stairs
○ Fall From Changing Table	○ Fall Off Monkey Bars	○ Other _____

Has this child ever sustained an injury playing organized sports? ○ Yes ○ No

If Yes, Please Explain: _____

Has this child ever sustained Injuries in an auto accident? ○ Yes ○ No

If Yes, Please Explain: _____

Does this child have a history of abuse? ☐ Yes ☐ No

If yes, has this child been to a professional counsellor? ☐ Yes ☐ No

Present History: _____

_____

_____

_____

Surgery: _____

_____

Medications: _____

_____

Accidents: _____

_____

Family History: _____

_____

Authorization for Care of Minor

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian)

Signed: _____ **Date:** _____

Witnessed: _____ **Date:** _____

I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided. X-rays remain the property of this office.

Signed: _____**Date:** _____