Awaken
Chiropractic and Wellness Center

Child New Patient

Drs. Jared Lane and Nicole Evans
405-515-9355

Child's Name _____ Date: _____

Parent(s) Names
_____

Siblings' Names and Ages
_____

Address _____ City/Town _____ Postal Code _____

Parents' E-mail Address
_____

Date of Birth _____m/_____d/_____y/ Gender: ○ Male ○ Female

Home Ph. _____ Business Ph. _____ Mobile Ph. _____

Best time/ place to contact you? _____

Whom may we thank for referring your child to this office? _____

Circle the phrase that most represents your child's reason for care:

○ Wellness ○ Prevention ○ Feel good ○ Symptom Relief

Reason for your child seeking services at our office: _____

Has your child ever seen a Chiropractor? If yes, who? Date of last visit: _____

Name & Address of Obstetrician/ Midwife:
_____

Name & Address of Primary Health Care Provider:
_____

Date of last visit _____ Purpose of visit _____

Health Concerns

Please list your child's heath concerns according to their severity:

Concern	Rate of Severity 1=mild, 10=worst	When did it start? For how long?	If you had the condition before, when?	Did the problem begin with an injury?	What % of time is pain present?
1.					
2.					
3.					

Pregnancy and Birth History

Gestational Duration: _____ weeks

PHYSICAL STRESS

Trauma/Falls during pregnancy_____

Any ultrasounds or other radiation? ◯ Yes ◯ No

How many and for what reasons? _____

Invasive Procedures (Eg. Amniocentesis, CVS) ? ◯ Yes ◯ No

CHEMICAL STRESS

During the pregnancy did the mother:

Smoke? ◯ Yes ◯ No How much? _____

Drink Alcohol? ◯ Yes ◯ No How much? _____

Prescription Medications? ◯ Yes ◯ No How much? _____

Recreational Drugs? ◯ Yes ◯ No How much? _____

Have an illness? ◯ Yes ◯ No Please explain_____

Were any supplements taken during the pregnancy? ◯ Yes ◯ No

Please list: _____

EMOTIONAL STRESS

Please rate your stress levels during pregnancy 1-10 (1= low, 10=high):_____

LABOR

Was labor induced? ◯ Yes ◯ No Duration of labor? _____

Duration of active (pushing stage) labor?_____

Did mother receive medications? ◯ Yes ◯ No

If yes, which: _____

BIRTH

Type of birth? ◯ Vaginal: Cephalic (head first) ◯ Breech (feet first) ◯ C-Section

Location of birth? ◯ Home ◯ Hospital ◯ Birthing center

Birth Assistants? ◯ Midwife ◯ Doula ◯ Obstetrician

Was there any assistance needed during birth?

◯ Forceps ◯ Cesarean ◯ Vacuum Extraction ◯ Induction ◯ Assisted Traction/Head Turning

Was delivery considered normal? ◯ Yes ◯ No Were there complications during birth? ◯ Yes ◯ No

Please explain:_____

Was there any evidence of birth trauma to the infant? Check all that apply:

- ◯ Bruising
- ◯ Odd shaped head
- ◯ Stuck in birth canal
- ◯ Fast or excessively long birth
- ◯ Respiratory depression
- ◯ Cord around neck

Was your child subjected to any of the following? Check all that apply:

- ◯ Silver nitrate drops in eyes
- ◯ Incubation How long? _____
- ◯ Vitamin K shot
- ◯ Separation from you How long? _____
- ◯ Hepatitis shot

Did your child spend any time in intensive care? ◯Yes ◯ No If yes, how long? _____

APGAR score at birth? _____ APGAR score at 5 minutes? _____

Birth Weight? _____ Birth Length? _____

Childhood History

PHYSICAL STRESS

Does your child have a preferred sleeping position? ◯ Yes ◯ No _____

Did your child prefer one-sided breast-feeding position? ◯ Yes ◯ No _____

Did your baby spit up after feeding? ◯ Yes ◯ No _____

Any falls or injuries down stairs, bicycle etc? ◯ Yes ◯ No _____

Does child ever bang his/her head repeatedly? ◯ Yes ◯ No _____

Any traumas resulting in bruises, fractures, stitches? ◯ Yes ◯ No _____

Any hospitalizations or surgeries? ◯ Yes ◯ No _____

Please list all surgeries your child has had:

1. Type _____ When _____ Doctor _____
2. Type _____ When _____ Doctor _____

Please list any accidents and/or injuries: auto, sports, or other (Especially those related to your child's present problems).

1. Type_____ When_____ Hospitalized? ◯ Yes ◯ No
2. Type_____ When_____ Hospitalized? ◯ Yes ◯ No
3. Type_____ When_____ Hospitalized? ◯ Yes ◯ No

Have you ever had x-rays taken? ◯ Yes ◯ No When?_____ Where?_____

What area of your child's body:_____

Does your child play sports? ○ Yes ○ No _____

If yes, hours per week? _____ Age child began? _____

Is school backpack used? ○ Yes ○ No Weight of backpack? _____kg/lbs

Approximate hours spent at play per week? _____

Average time spent at computer/TV/video games per week? _____ hrs

Does your child wear glasses or contact lenses? ○ Yes ○ No _____

Does your child have trouble reading the board? ○ Yes ○ No _____

Does your child have difficulty with coordination? ○ Yes ○ No _____

CHEMICAL STRESS

Was/is child breast-fed? ○ Yes ○ No For how long? _____

At what age was:

Formula introduced? _____Brand? _____

Cow's milk introduced? _____

Solid food? _____

Food/juice intolerance? ○ Yes ○ No_____

Does your child have food allergies? ○ Yes ○ No_____

What is your child's favorite food? _____

What does your child regularly drink? _____

The type of diet your child usually follows is classified as: _____

Please circle any dietary selection that is appropriate for your child, and grade according to the following scale:

Daily:
D - Consume this daily
FD - Consume this a few times per day

Monthly:
M - Consume this monthly
FM - Consume a few times per month

Weekly:
W - Consume this weekly
FW - Consume this a few times per week

Never:
O - Do not consume this

Eggs_____	Fasting_____	Fruit_____	Fish _____	Diet Food _____
Organic Foods _____		Coffee _____	Beef _____	Weight Control Diet _____
Raw Vegetables _____		Soft Drink _____	Poultry _____	Artificial Sweetener _____
Whole Grains _____		Fried Foods _____	Seafood _____	Cooked vegetables _____
Refined Sugar _____		Dairy _____	Canned/Frozen vegetable _____	

Does your child have a bowel movement every day? ○ Yes ○ No _____

Does your child have regular or occasional skin rashes? ○ Yes ○ No _____

What vaccinations were given and at what age?

_____

_____

Reason for vaccinations _____

Were there any negative reactions? ○ Yes ○ No _____

Was there any:

- ○ Fever
- ○ Un-consolable crying
- ○ Irritability
- ○ Arching of body
- ○ Bowel disturbances
- ○ Feeding disturbances
- ○ Drowsiness
- ○ Other: _____

History of antibiotics? ○ Yes ○ No

If so, how many courses of antibiotics has your child received in their lifetime? _____

Reason and length of last course of antibiotics? _____

Please list ALL medications your child currently takes or has taken in the past 6 months:

Name _____ Dosage _____ For what? _____

Name _____ Dosage _____ For what? _____

Name _____ Dosage _____ For what? _____

Please list all nutritional supplements, vitamins, homeopathic remedies your child presently takes:

Name _____ For what? _____

Name _____ For what? _____

Are there pets in the home? ○ Yes ○ No _____

Are there any smokers at home? ○ Yes ○ No _____

EMOTIONAL STRESS

Did mother have any difficulties with breast-feeding? ○ Yes ○ No

Did mother and baby have difficulty bonding? ○ Yes ○ No

Did mother experience any post-partum depression? ○ Yes ○ No

Night terrors, sleep walking, difficulty sleeping ○ Yes ○ No

Do you consider their sleeping pattern normal? ○ Yes ○ No

Quality of Sleep? ○ Good ○ Fair ○ Poor Number of hours: _____

Behavior problems? ○ Yes ○ No _____

Do you feel that your child's social / emotional development is normal for their age? ○ Yes ○ No

Does / did your child attend day care? ○ Yes ○ No From what age? _____

GROWTH AND DEVELOPMENT

Was your child alert & responsive within 12 hours of delivery? ◯ Yes ◯ No

If no, please explain: _____

At what age did your child:

Respond to sound?	_____	Sit alone?	_____
Follow an object?	_____	Teethe?	_____
Hold head up?	_____	Crawl?	_____
Vocalize?	_____	Walk?	_____

FAMILY HISTORY

Describe any medical family history on mother's side: (EG cancer, diabetes etc)

_____

On father's side:

_____

Do siblings have any health concerns? ◯ Yes ◯ No

If yes, please describe: _____

I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____