CHILD PRACTICE MEMBER FORM

AUTHORITY CHIROPRACTIC

OFFICE USE ONLY

C	ID#
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T	INS
ABR	Y/N

PERSONAL INFORMATION

Child's Name : Gender: Male Female

Address : □ity: State: Zip □ode:

Date of Birth : Age: Current Height: □ eight:

Mother's Name: Mother's Date of Birth :

Mother's Mobile: Mother's Last 4 SSN: Father's Mobile:

Father's Name: Father's Date of Birth :

Pediatrician/Family MD: City/State:

Last Visit: Reason For Last Visit:

Who may we thank for referring you?

PURPOSE OF THIS VISIT

What health concerns bring you into our office? Wellness Checkup Injury or Accident Other:

Please explain:

Have you received care for this problem before? Yes No - If yes, when?

If Yes: Chiropractor Medical Doctor Other:

If Yes: Who? Results?

How did the problem(s) start? Suddenly Gradually Post-Injury

This condition is: Getting Worse Improving Intermittent Constant Unsure

If your child is experiencing pain/discomfort, please identify. where and for how long:

Please list any medications your child takes and for what reason:

Has your child ever sustained an injury playing organized sports? Yes No If yes, please explain:

Has your child ever sustained an injury in an auto accident? Yes No If yes, please explain:

Was your child born before 40 weeks gestation? ◯ Yes ◯ No If yes, please explain:

My child was born: ◯ Vaginal Birth ◯ Cesarean/C-Section

Did your child sustain any trauma during labor/delivery? ◯ Yes ◯ No If yes, please explain:

Covid Vaccine? ◯ Yes ◯ No

Other vaccine history: ◯ Fully ◯ Partially ◯ No Vaccines

HAS/DOES YOUR CHILD SUFFER FROM: *Check all that apply*

Past	Current	
☐	☐	Headaches
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Seizures/Convulsions
☐	☐	Heart Trouble
☐	☐	Chronic Earaches
☐	☐	Sinus Trouble
☐	☐	Scoliosis
☐	☐	Bed Wetting
☐	☐	Fall from bed or couch
☐	☐	Fall from high chair
☐	☐	Behavioral Problems
☐	☐	ADD/ADHD
☐	☐	Ruptures/Hernia
☐	☐	Muscle Pain

Past	Current	
☐	☐	Orthopedic Problems
☐	☐	Neck Problems
☐	☐	Arm Problems
☐	☐	Leg Problems
☐	☐	Joint Problems
☐	☐	Backaches
☐	☐	Poor Posture
☐	☐	Anemia
☐	☐	Broken Bones
☐	☐	Fall from crib
☐	☐	Fall from changing table
☐	☐	Growing Pains
☐	☐	Asthma
☐	☐	Hypertension
☐	☐	Sleeping Problems

Past	Current	
☐	☐	Digestive Disorders
☐	☐	Poor Appetite
☐	☐	Stomach Ache
☐	☐	Reflux
☐	☐	Colic
☐	☐	Latching/Feeding Difficulty
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Colds/Flu
☐	☐	Fall down stairs
☐	☐	Fall off slide/playground
☐	☐	Walking Trouble
☐	☐	Fall in baby walker
☐	☐	Fall off bicycle

☐ Other:

Please list any allergies:

Notes: