Patient Information

Date ______________________

Patient's Name: ____

Supplemental Infant/Child Assessment Form

Place of birth: ○ Home ○ Birthing Center ○ Hospital ○ Other, please list: ______________________

Type of Birth: ○ C-section ○ Vaginal

Was ultrasound used during pregnancy? ○ Yes ○ No If yes, how many times: ______________________

Was labor induced? ○ Yes ○ No If yes, why: ____

____

Was Anesthesia used? ○ Yes ○ No Type(s) of Anesthesia use: ______________________________

____

Was there any notable Doctor assisted birth trauma? ○ Twisting or Pulling ○ Vacuum Extraction ○ Forceps ○ Other: ___

____

Were there any special medical procedures or tests performed? ○ Yes ○ No If yes, please list: ______________

____

Was the child breast fed? ○ Yes ○ No If yes, to what age: ______________________________

According to the National Safety Council, over 50% of all infants fall from a place 4ft or higher during their first 2 years of life.

Can you recall ANY jolts, falls, or traumas to this child? ○ Yes ○ No If yes, please describe: ______________

____

Has this child experienced any fractures or dislocations? ○ Yes ○ No Please describe:______________

Other than the time spent sitting in a classroom, does your child spend prolonged time sitting? ○Yes ○ No

Which activities does this child participate in? ○ Soccer ○ Football ○ Gymnastics ○ Karate ○ Hockey ○ Basketball ○ Video Games ○ Dance ○ Wrestling ○ Baseball ○ Softball ○ Cheerleading ○ Other: ______________

How would you rate your child's overall diet? ○ Poor ○ Somewhat Healthy ○ Healthy

Please mark any of the following conditions your child has experienced: ○ Colic ○ Irregular Sleeping Patterns ○ Nightmares ○ Seizures ○ Tantrums ○ Ear Infections ○ Allergies ○ Asthma ○ Headaches ○ Poor Digestion ○ Repeated Infections or Colds ○ Bed Wetting ○ Learning Disorders ○ Emotional Disorders ○ ADD or ADHD ○ Other: ______________

____

Please list all medications your child has been treated with since birth: ______________________________

____

____

Were you informed of any adverse reactions to any of the above listed medications? ○ Yes ○ No

Authorization

I hereby authorize the Doctors and Staff at Adjust Life to examine and treat my ○ Son ○ Daughter. Having carefully read the attached informed consent, I hereby give my informed consent to have chiropractic treatment administered.

Parent/Legal Guardian Signature: ______________________________ Date: ______________

Personal Information

Name of Child:____

Child's Birth Date:________________________ Primary Phone #:____

Address:____

City/ State/ Zip:____

Mother's Name: ____ Birth Date:_______________________________

Home Phone: ( )____________________________ Work Phone: ( )_____________________________________

Mobile Phone: ( )____________________________ Email: ____

Father's Name:____ Birth Date:______________________________

Home Phone: ( )____________________________ Work Phone: ( ) _____________________________________

Mobile Phone: ( ) ___________________________ Email: ____

Primary Insurance Coverage:____

Secondary Insurance Coverage:____