ABOUT THE PATIENT

Name: _____ Birth Date: _____

Name of Parents/ Guardians: _____

Siblings' Names: _____ Ages: _____

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

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

Who referred you to this office? _____

REASON FOR THIS VISIT

Which best describes your reason for consulting our office? (Please check ONE)

☐ Crisis Management ☐ Early Detection of Problems ☐ Maximizing Normal Growth & Development

When and how did this health challenge begin? _____

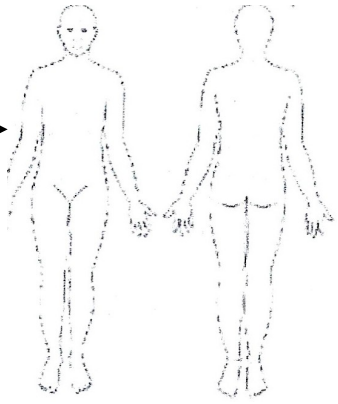
_____

_____

Since the problems began, is it: (Please check ONE)

☐ Better ☐ Worse ☐ About the Same

Using the diagram on the right, please indicate with an **X** where you or your child notices discomfort or problems occurring.



What is the pattern of this problem? (Please check ONE)

☐ Constant ☐ Intermittent ☐ Occasional ☐ Cyclic

Does this interfere with your child's sleep? ☐ Yes ☐ No

Does this interfere with your child' s eating habits? ☐ Yes ☐ No

What have you tried to improve this condition? _____

The human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability. This interference is most commonly the result of vertebral subluxations. Subluxations may be caused by physical, chemical, or emotional stress. The practice of chiropractic is based on locating and reducing nerve system interference caused by the vertebral subluxations.

HEALTH HISTORY

Have you or your child been adjusted by a chiropractor before? ☐ Yes ☐ No

If yes, for what reason: _____

Name of pediatrician: _____ Date of last visit: _____ Reason: _____

Number of doses of antibiotics your child has taken:

During past 6 months_____ Total during lifetime: _____

Number of doses of other prescription medications your child has taken:

During past 6 months_____ Total during lifetime: _____

Please list: _____

Please list any OTC drugs taken in the past six months _____

Has your child ever been hospitalized, had any surgeries or major illnesses? ☐ Yes ☐ No

If yes, please explain: _____

Vaccination History _____ Any reactions? _____

Have you withheld any vaccines? ☐ Yes ☐ No

Explain: _____

Please check any of the following conditions that your child has now or had previously. While they may seem unrelated to the purpose of this appointment, they can affect the overall diagnosis and care plan.

☐ Colic	☐ Seizures	☐ Scoliosis	☐ Recurring fevers
☐ Ear Infections	☐ Bed Wetting	☐ Headaches	☐ Digestive problems
☐ Chronic Colds	☐ Hyperactivity	☐ Back Pain	☐ Acid Reflux
☐ Asthma	☐ Temper Tantrums	☐ Growing Pains	☐ Poor Nutrition
☐ Allergies	☐ Sleeping problem	☐ Car Accident	☐ Limited Exercise
☐ Sinus Problems	☐ Anxiety/ADHD	☐ Dizziness	☐ Low Energy

☐ Other: _____

GROWTH AND DEVELOPMENT

Was your child ale1t and responsive within 12 hours of delivery? ☐ Yes ☐ No

If yes, please explain _____

At what age did the child: ☐ Respond to sound ☐ Follow an object ☐ Hold up Head ☐ Vocalize
☐ Sit Alone ☐ Teethe ☐ Crawl ☐ Walk

Does your child sleep on their: ☐ Front ☐ Back ☐ Side How many hours per day? _____

Do you consider your child' s sleeping pattern to be normal? ☐ Yes ☐ No

If no, please explain: _____

CHEMICAL STRESSES

Was this child breastfed? ? ☐ Yes ☐ No If yes, how long? _____

What age was formula introduced? _____ Which formula? _____

What age was cow milk introduced? _____ What age was solid food introduced? _____

List the types of solid food introduced: _____

Food or juice intolerance? _____

List any illnesses during pregnancy: _____

List any supplements taken during pregnancy: _____

List any drugs taken during pregnancy: _____

Did the mother have any ultrasounds ☐ Yes ☐ No If yes, how many? _____

Were there any invasive procedures during pregnancy (Amniocentesis, Chorionic Villi Sampling, etc)? ☐ Yes ☐ No

If yes, please list _____

Are there any pets at home ? ☐ Yes ☐ No Are there any smokers in the home ? ☐ Yes ☐ No

Is the diet organic ? ☐ Yes ☐ No Do you use " Green products" in your home for cleaning ? ☐ Yes ☐ No

How often does your child receive processed foods, white sugar, gluten (flour), or dairy in their diet?

☐ Never ☐ On special occasions ☐ On weekends ☐ A few times per week ☐ Daily ☐ Nearly each meal

Are you aware of the impact of nutrition on children's behavior? ☐ Yes ☐ No

Would you like information on nutrition for your child? ☐ Yes ☐ No

PSYCHOSOCIAL STRESSES

Are/ were there any difficulties with lactation? ☐ Yes ☐ No If yes, explain: _____

Are/were there any problems with bonding? ☐ Yes ☐ No If yes, explain: _____

Are there any behavioral problems? ☐ Yes ☐ No If yes, explain: _____

Is there any inattention? ☐ Yes ☐ No Hyperactivity/restless? ☐ Yes ☐ No Compulsiveness? ☐ Yes ☐ No

Are there any difficulties at daycare or school? ? ☐ Yes ☐ No

Are there any challenges with learning deficiencies? ? ☐ Yes ☐ No

Are there any night terrors, sleep walking or difficulty sleeping? ? ☐ Yes ☐ No

Are there any prolonged temper tantrums or separation anxiety? ? ☐ Yes ☐ No

Is the child in daycare? ☐ Yes ☐ No If yes, what age did they begin? _____

Is there a nanny or regular sitter during the day? ☐ Yes ☐ No

Is the child home-schooled? ☐ Yes ☐ No

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

If no, explain: _____

AUTHORIZATION FOR CARE OF MINOR

In order for the health professional as indicated below to make a determination on the suitability of my child's/guardian' s case for care, I acknowledge and understand that a thorough evaluation must be completed. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in the child' s interests.

Patient or Authorized Person's Signature: _____ Date: _____

Doctor's Signature: _____