ABOUT THE PATIENT

Name:_____ Birth Date:_____

Name of Parents/ Guardians:_____

Siblings' Names and 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?_____

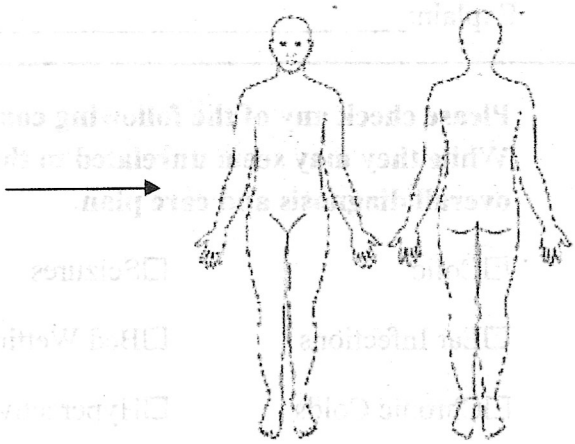
_____

_____

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? __No __Yes

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 problems	☐Car Accident	☐Limited Exercise
☐Sinus Problems	☐Anxiety/ADHD	☐Dizziness	☐Low Energy

☐ Other: _____

GROWTH AND DEVELOPMENT

Was your child alert and responsive within 12 hours of delivery? __Yes __No, 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? __No __Yes 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 __No __Yes If yes, how many?_____

Were there any invasive procedures during pregnancy (Amniocentesis, Chorionic Villi Sampling, etc)?

__No __Yes, please list_____

Are there any pets at home? __No __Yes Are there any smokers in the home? __No __Yes

Is the diet organic? __No __Yes Do you use "Green products" in your home for cleaning? __No __Yes

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? __No __Yes

Would you like information on nutrition for your child? __No __Yes

PSYCHOSOCIAL STRESSES

Are/ were there any difficulties with lactation? __No __Yes, explain:_____

Are/were there any problems with bonding? __No __Yes, explain:_____

Are there any behavioral problems? __No __Yes, explain:_____

Is there any inattention? __No __Yes Hyperactivity/restlessness __No __Yes Compulsiveness? __No __Yes

Are there any difficulties at daycare or school? __No __Yes

Are there any challenges with learning deficiencies? __No __Yes

Are there any night terrors, sleep walking or difficulty sleeping? __No __Yes

Are there any prolonged temper tantrums or separation anxiety? __No __Yes

Is the child in daycare? __No __Yes If yes, what age did they begin?_____

Is there a nanny or regular sitter during the day? __No __Yes

Is the child home-schooled? __No __Yes

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:_____