

1. Patient Information

Patient Number _____

Name _____

Date _____

Address

Social Security Number _____

Home phone _____ Date of Birth _____ Age _____

Gender _____

Emergency Contact Name and Number

Who may we thank for referring you?

2. Reason for Care

Reason for this visit

When did this condition first appear?

Describe this condition

Is this condition getting worse?

Is this the first time your child has experienced this condition?

If no, explain

Rate how bad it is on a scale of 1 – 10 with 1 being the worst 1 2 3 4 5 6 7 8 9 10

How often does your child experience this condition

What Activities are difficult to perform due to this condition?

Play _____ Sleep _____ Eating _____

Sports _____

Other

Have you ever tried Chiropractic before? _____

If yes, please explain (who, where, when & why)

What treatments have you attempted for this problem?

Medicine (s)

Surgery

Physical Therapy

What makes this condition better?

What makes this condition worse?

3. Health History

Name of Last Physician or Pediatrician

_____ Phone _____

Address

Reason for Last Visit

Are you satisfied with your Pediatrician Yes No

Why

Daily Stress

Physical

Chemical

Emotional

Poor Habits

Caffeine Soda / Sweet tea High Fat Foods Sweets

Good Habits

Healthy Diet Good Sleep Moderate Exercise Good Attitude Drinking Plenty of Water

Injuries _____

Broken Bones _____

Sprains _____

Dislocations _____

Automobile Accidents (List every one, most recent first)

Major Illnesses

Cancer _____

Birth and Developmental History

Y N Normal Pregnancy

Y N Complications during pregnancy _____

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Y N Complications at birth _____

Y N C-Section

Y N Breach Presentation

Y N Forceps Delivery

Y N Vacuum Extraction

Y N Drugs at or before Birth

Place of Birth Home _____ Birthing Center _____
Hospital _____

Y N Was your child late in their development or did your child have any birth defects? _____

Y N Breast fed, Did your child nurse equally on both sides? Y N

Y N Formula fed, List Type(s) _____

Y N Was your child vaccinated?

Y N Has your child ever had a vaccine reaction? (seizures, brain inflammation, kidney failure, autism, screaming,

convulsions, fever, irritability, limping, developmental back-tracking, mental retardation, diarrhea, respiratory

distress, vomiting, behavioral changes, blank stare, projectile vomiting or any other reactions)

Birth Weight _____

Birth Length _____

What age was your child able to:

Hold head up _____

Sit up alone _____

Crawl _____

Stand _____

Walk _____

What age was solid food first introduced and what type?

What age was Cow's milk first introduced?

List all childhood diseases (ear infections, colic, asthma, allergies, recurrent strep, constipation, etc.) _____

List all medications given to your child _____
