Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us better serve you, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____Address:_____
City: _____State: _____Zip Code: _____

Home phone: _____Cell phone: _____

Birth Date: _____/_____/_____ Age: _____ Sex: _____ Weight: _____ Height: _____

Referred by: _____Names of Parents/Guardians: _____

Reason for Visit?

_____

Have you seen other doctors for this condition: ____Y ____N

Doctos' names and prior treatments:

_____

_____

Other health problems:

_____

Check any of the following conditions your child has suffered from during the past six months:

☐ Ear Infections	☐ Scoliosis	☐ Seizures	☐ Chronic Colds	☐ Headaches
☐ Asthma/ Allergies	☐ Digestive Problems	☐ ADHD	☐ Recurring Fevers	☐ Growing/Back Pains
☐ Colic	☐ Bedwetting	☐ Car Accident	☐ Temper Tantrums	Other_____

Family History: _____

Previous Chiropractor: _____

Date of last visit: ___/___/___ Reason: _____

Name of Pediatrician: _____

Date of last visit: ___/___/___ Reason: _____

Are you satisfied with the care your child has received there? ___Y ___N

If no, why were you dissatisfied? _____

Number of doses of antibiotics your child has taken:

During the past six months: _____ Total during his/her lifetime: _____

Medications: (Please list ALL medications and daily dosage in MG)

☐ I am **NOT** currently taking any medications

Name:_____ Daily Dosage: _____MG

Name:_____ Daily Dosage: _____MG

Name:_____ Daily Dosage: _____MG

Medication Allergies: Please list all medication allergies below:

☐ Penicillin ☐ Sulfa Drugs ☐ Anticonvulsants ☐ Insulin
☐ Antibiotics (please specify type): _____ ☐ Other: _____

☐ I have **NO KNOWN** medication allergies.

Vaccination history:

_____

Prenatal History:

Name of obstetrician/midwife:

_____

Any complications during pregnancy? ____Y ____N List: _____

Any ultrasounds during pregnancy? ____Y ____N How many? _____

Any medications during pregnancy/delivery? ____Y ____N List: _____

Cigarette/alcohol use during pregnancy: ____Y ____N

Location of birth: ☐ Hospital ☐ Birthing Center ☐ Home

Birth intervention: ☐ Forceps ☐ Vacuum extraction ☐ Cesarean section - Emergency or Planned?

Genetic disorders or disabilities: ____Y ____N List: _____

Birth weight: _____ Birth length: _____ APGAR scores : _____ , _____

Feeding History:

Breast fed: ____Y ____N How long?: _____

Formula fed: ____Y ____N How long?: _____

Introduced to solids at: _____ Months Cow's milk at _____ months

Food /juice allergies or intolerance: ____Y ____N List:

_____

Developmental History:

During the following times, your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference.)

At what age was your child able to:

Respond to sound: ____ Cross crawl: ____

Respond to visual stimuli: ____ Stand alone: ____

Hold head up sit up: ____ Walk alone: ____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.) Was this the case with your child? ____Y ____N

Is/has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball

Cheerleading, Martial Arts, etc.?) ____Y ____N List:

_____

Has your child ever been involved in a car accident? ____Y ____N List: _____

Has your child been seen on an emergency basis? ____Y ____N List: _____

Other traumas not described above? ____Y ____N List: _____

Prior surgery: ____Y ____N List: _____

Childhood Diseases:

☐ Chicken Pox Age: _____

☐ Rubella Age: _____

☐ Rubeola/Measles Age: _____

☐ Mumps Age: _____

☐ Whooping Cough Age: _____

☐ Other Age: _____

WE ARE HERE TO SERVE YOU AND YOUR FAMILY AND ENCOURAGE YOU TO ASK QUESTIONS.

YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR CHILD'S RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company: _____ Policy # _____

Signed: _____ **Date**: ____/____/____