

Child's Name: _____ Name the child prefers to be called: _____

Name of Mom, Dad, or guardian: _____

Address: _____ DOB: _____ Age: _____ Gender: M F

City: _____ State: _____ Zip: _____ Home #: _____ Cell #: _____

SS#: _____ - _____ - _____ Family E-mail: _____

Best place to reach you: Home Cell Work: () _____ ext: _____

Children's Siblings and ages (if applicable): _____

Who is your child's primary care doctor? _____
(Please list the name of your child's doctor and the facility)

May we contact him or her about your care? Y N Were you referred by him or her? Y or N

Insurance Information

Are your child's symptoms related to an accident? Y N Automobile Work Other Date: ____/____/____

Current Complaints

Major complaints and symptoms: 1) _____
2) _____
3) _____

How do you believe the child's problem or pain began? _____

Has your child seen any provider for this condition?

What did they do, and did it help?

1. _____ Y N

2. _____ Y N

Vitamins and Supplements

Allergies

Medications

During the Pregnancy, Did you use or have any of the following:

Tobacco..... No Yes: _____
Alcohol..... No Yes: _____
High Blood Pressure..... No Yes: _____
Diabetes (Type 1, Tpye 2, or Gestational)..... No Yes: _____
Anemia..... No Yes: _____

Please Check Any of the Following that Occurred While Pregnant With This Child:

	No	Yes	Describe
Falls.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Motor Vehicle Accidents.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Morning Sickness/Nausea.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Indigestion.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swollen Ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Back Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rib / Breathing Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abnormal Bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Premature Contractions.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bed Rest.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pre-eclampsia.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any Other Illnesses.....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please Answer the Following Questions: (if the answer is yes, please describe briefly)

Was this child born Premature? N Y If yes, at what week was your child born? _____

Were there complications with your child's health following delivery? N Y: _____

Has your child experienced any significant illnesses? N Y

If yes, please list the illnesses your child has experienced: _____

Have you noticed any unusual rashes or markings? N Y: _____

Does your child experience ear aches or redness around the ears? N Y

Has your child had an ear infection? N Y If yes, how many? _____

Has your child had antibiotics? N Y If yes, how many treatments? _____

Has your child been vaccinated? N Y

If yes, when was your child's last vaccination? _____

Any problems with Constipation? N Y: _____

Any problems with Diarrhea? N Y: _____

Has your child received chiropractic care before? N Y If yes, when was their last treatment? _____

Do you have any other concerns regarding your child's health? _____
