

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? \_\_\_\_\_