Welcome to Our Office!
Please answer the following questions so we can better understand your child's specific health needs.

Child Information

Child's Name ________________________________Parent(s) Names____

Siblings' Names and Ages ____

Address ____

Parents' E-mail Address ____________________________Would you like to receive our e-newsletter? ☐ Yes ☐ No

Date of Birth ________________ Age _______ Gender: ☐ Male ☐Female

Home Phone ______________________ Work Phone ______________________ Cell Phone ______________________

Best Time to Reach You: ☐ Morning ☐ Afternoon ☐ Evening Preferred Contact: ☐ Phone ☐ Email

Whom may we thank for referring your child to this office? ____

Reason for your child seeking services at our office:______________________(i.e. Wellness, Specific Health Concern)

Has your child ever seen a Chiropractor? If yes, who? Date of last visit: ______________________________________

Name of Primary Health Care Provider: ____

Health Concerns

Please list your child's heath concerns according to their severity:

Health Concern ___________________________When did this episode start? ____________________________

If they have had this condition before, when? _________Did the problem begin with an injury? ☐ Yes ☐ No

Severity (mild) 1 2 3 4 5 6 7 8 9 10 (worst imaginable)

Since its onset, it is: ☐ Getting Better ☐ About the Same ☐ Getting Worse

Are you currently seeing other health care professionals for this health challenge? ☐ Yes ☐ No

☐Osteopath ☐Chiropractor ☐Medical Doctor ☐Physical Therapist ☐Massage Therapist ☐Acupuncturist

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Childhood History

PHYSICAL STRESS

Trauma/Falls during Mother's pregnancy? ☐ Yes ☐ No ____

Type of birth? ☐ Vaginal ☐ C-Section Presentation: ☐ Cephalic (head first) ☐ Breech (feet first)

Was there any assistance needed during birth? (check all that apply)

☐Forceps ☐Cesarean ☐Vacuum Extraction ☐Induction ☐Assisted Traction/Head Turning

Was there any evidence of birth trauma to the infant? Check all that apply:

☐Bruising ☐ Asymmetrical head shape ☐ Fast or excessively long birth

☐ Respiratory depression ☐ Cord around neck

Does your child have a preferred sleeping position? ☐ Yes ☐ No ______________________________

Did your child prefer one-sided breast-feeding position? ☐ Yes ☐ No ______________________________

Did your baby spit up after feeding? ☐ Yes ☐ No ______________________________

Does child ever bang his/her head repeatedly? ☐ Yes ☐ No ______________________________

Has your child had any surgeries? ☐ Yes ☐ No If yes, please list surgeries below:

1. Type ____________________When ________ Doctor ________________

2. Type ____________________When ________ Doctor ________________

3. Type ____________________When ________ Doctor ________________

Please list any accidents and/or injuries (Especially related to your child's present problems):

1. Type________________ When __________ Hospitalized? ☐Yes ☐ No

2. Type________________ When__________ Hospitalized? ☐Yes ☐ No

3. Type________________ When__________ Hospitalized? ☐Yes ☐ No

Has your child ever had x-rays taken? ☐ Yes ☐ No When?________ Where?________________

What area of your child's body:______________________________________

Does your child play sports? ☐ Yes ☐ No If yes, hours per week? _______ Age child began? _______

Average hours spent: At play per week? _____hrs Screen time (computer/TV/video games) per week? _____hrs

Do you worry about your child's balance/coordination? ☐Yes ☐ No______________________________

CHEMICAL STRESS

Was/is your child breast-fed? ☐Yes ☐ No For how long? ________________

At what age was: Formula introduced? _________Cow's milk introduced? _________Solid food introduced? _________

Does your child have food allergies/intolerances? ☐ Yes ☐ No______________________________

What is your child's favorite food? __________What does your child regularly drink? __________

Does your child have a bowel movement every day? ☐ Yes ☐ No ______________________________

Does your child have regular or occasional skin rashes? ☐ Yes ☐ No ______________________________

Did your child receive immunizations? ☐ Yes ☐ No

If Yes, did they experience any of the following reactions ? (check all that apply)

☐ Inconsolable crying ☐ Irritability ☐ Arching of body ☐ Rash or Itch

☐ Bowel disturbances ☐ Fever ☐ Feeding disturbances ☐ Drowsiness

☐ Other: ______________________________________

History of antibiotics? ☐ Yes ☐ No If yes, how many courses has your child received in their lifetime?__________

Reason for last course of antibiotics? ______________________________________

Please indicate how often your child consumes the following based on the provided scale:

FD – Consume a few times per day **D** – Consume daily **FW** – Consume a few times per week
W – Consume weekly **FM** – Consume a few times per month **M** – Consume monthly **0** – Does not consume

Artificial Sweetener	FD D FW W FM M 0	Fish	FD D FW W FM M 0
Beef	FD D FW W FM M 0	Fresh Fruit	FD D FW W FM M 0
Canned Vegetables	FD D FW W FM M 0	Fried Foods	FD D FW W FM M 0
Coffee	FD D FW W FM M 0	Organic Foods	FD D FW W FM M 0
Cooked Vegetables	FD D FW W FM M 0	Poultry	FD D FW W FM M 0
Dairy	FD D FW W FM M 0	Raw Vegetables	FD D FW W FM M 0
Diet Foods	FD D FW W FM M 0	Refined Sugar	FD D FW W FM M 0
Eggs	FD D FW W FM M 0	Seafood	FD D FW W FM M 0
Fast Food	FD D FW W FM M 0	Soda	FD D FW W FM M 0
Fasting	FD D FW W FM M 0	Whole Grains	FD D FW W FM M 0

Please list ALL **medications** your child currently takes or has taken in the past 6 months:

Medication____________________Taken for____________________

Medication____________________Taken for____________________

Medication____________________Taken for____________________

Please list all nutritional supplements, vitamins, homeopathic remedies your child presently takes:

Supplement ____________________ Taken for ____________________

Supplement ____________________ Taken for ____________________

Supplement ____________________ Taken for ____________________

Are there pets in the home? ☐ Yes ☐ No__________ Are there any smokers at home? ☐ Yes ☐No__________

EMOTIONAL STRESS

Did mother have any: ☐ difficulties with breast-feeding ☐ difficulty bonding w/baby ☐ post-partum depression?

Has your child experienced night terrors, sleep walking, difficulty sleeping? ☐ Yes ☐ No ________________

Do you consider their sleeping pattern normal? ☐ Yes ☐ No ____________________

Quality of Sleep? ☐ Good ☐ Fair ☐ Poor Average number of hours of sleep per night?________________

Has your child experienced behavior problems? ☐ Yes ☐ No ____________________

Do you feel that your child's social and emotional development is normal for their age? ☐ Yes ☐ No

Does your child attend day care? ☐ Yes ☐ No From what age? ________________

GROWTH AND DEVELOPMENT

At what age did your child:

Respond to sound? ______ Sit alone? ______ Follow an object? ______ Teethe? ______

Hold head up?______ Crawl? ______ Vocalize? ______Walk?______

FAMILY HISTORY

Please list any medical family history on mother's and/or father's side: (i.e. cancer, diabetes, heart disease etc)

____

Do siblings have any health concerns? ☐Yes ☐ No If yes, please describe: ____________________

The above information that I have provided is complete, true and accurate to the best of my knowledge.

Signature______________________________Date ____________