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 serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: ______________________________ S.S. #: ______________________

Address: ______________________________ City: ______________________

State: ____________ Zip: ______________ Home Phone: ______________________

Birth Date: ______/______/______ Work Phone: ______________________

Sex: ______ Weight: ______ Height: ______ Referred By: ______________________

Names of Parents/Guardians ______________________________

Purpose For Contacting Us? ______________________________

Other Doctors Seen for this Condition? ______N ______Y Doctors' 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
- ☐ Asthma/Allergies
- ☐ Colic
- ☐ Scoliosis
- ☐ Digestive Problems
- ☐ Bed Wetting
- ☐ Seizures
- ☐ ADHD
- ☐ Car Accident
- ☐ Chronic Colds
- ☐ Recurring Fevers
- ☐ Temper Tantrums
- ☐ Headaches
- ☐ Growing/Back Pains
- ☐ 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? ______N ______Y

Number of Doses of Antibiotics Your Child has Taken:

During the Past Six Months: ______, Total During His/Her Lifetime: ______

Number of Doses of Other Prescription Medications Your Child has Taken:

During the Past Six Months: ______, Total During His/Her Lifetime: ______ List: ______________

Vaccination History: ______________________________

Prenatal History:

Name of Obstetrician/Midwife: ______________________________

Complications During Pregnancy? ______N ______Y, List: ______________________

Ultrasounds During Pregnancy? ______N ______Y, Number ______

Medications During Pregnancy? ______N ______Y, List: ______________________

Cigarette/Alcohol Use During Pregnancy: ______N ______Y

Location of Birth: ______ Hospital ______ Birthing Center ______ Home

Birth Intervention: ________ Forceps ________ Vacuum Extraction

________ Caesarean Section, Emergency or Planned?

Complications During Delivery? ________N ________Y, List: ____

Genetic Disorders or Disabilities: ________N ________Y, List ____

Birth Weight: ________ Birth Length: ________ APGAR Scores ________, ________

Feeding History:

Breast Fed: ________N ________Y, How Long? ________

Formula Fed: ________N ________Y, How Long? ________ Type: ________________________________

Introduced to Solids at: ________ Months, Cows' Milk at ________ Months

Food/Juice Allergies or Intolerances: ________N ________Y, List: ________________________________

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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

________ Respond to Visual Stimuli

________ Hold Head Up

________ Sit Up

________ Cross Crawl

________ Stand Alone

________ 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? ________N ________Y

Is/has your child been involved in any high impact of contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? ________N ________Y, List: ________________________________

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Has your child ever been involved in a car accident? ________N ________Y, List: ________________________

Has your child ever been seen on an emergency basis? ________N ________Y, List: ________________________

Other Traumas Not Described Above? ________N ________Y, List: ________________________

Prior Surgery: ________N ________Y, List:

Menarche: ________N ________Y, Age: ________

Childhood Diseases:

Chicken Pox	N/Y, Age ________	Mumps	N/Y, Age ________
Rubella	N/Y, Age ________	Whooping Cough	N/Y, Age ________
Rubeola	N/Y, Age ________	Other	N/Y, Age ________

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR 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: ________________________________ Witnessed by: ________________________Date: ________/________/________