About the Child:

Last Name: ________________________________First: ____

Gender: Male Female Date of Birth: _______________ Age: _____ SS#____________________

About the Parents:

Name: ________________________________Birthdate____________Age:______Phone_____________

Address: ______________________________City: ________________State: ______ Zip: ____________

Email: ____________________________ Employer: __________________ Wk Phone: ______________

Insurance: ________________________Insured's Name: ________________ Insured's DOB: _________

Reason for Visit: **(Please select any of the applicable reasons for pursuing chiropractic care for your child)**

__ He/she is continuing care from another chiropractor

__ I recently had my spine checked and see the value in a family subluxation check-up.

__ I talked with the doctor and he suggested that I get my child checked.

__ I'm concerned about his/her health and am looking for answers

__ He/she has a specific condition that concerns me.

If so, please explain:

____

____

Is the condition related to: A Fall Sports injury Auto accident Other_______________________

When did this condition begin:____

Has the condition been: Staying the same Getting worse Getting better

Have you seen other Doctors for this condition? ____

Childs Health History:

Please circle all that apply or have applied to your child:

Allergies	Asthma	ADD/ADHD	Autism/PDD	Seizures
Colic	Constipation	Digestive Problems	Ear Problems/tubes	Frequent Cold
Headaches	Growing Pains	Sleeping Disorders	Scoliosis	Sinus Problems

Other: ____

Do you have family members with similar health concerns? ______ If yes, who? _________________________

Known allergies: ____

Has your child ever been on antibiotics? YES NO

If yes, number of doses within the past 6 months: ______ Total during lifetime: ______

List any current medications? ____

List any past medications? ____

Prenatal History

During your pregnancy, did you use: Drugs Tobacco Medications Alcohol
Please describe:____

	Describe your delivery:	Please Explain:
YES or NO	Labor was chemically induced	____________________________________
YES or NO	C-Section delivery	____________________________________
YES or NO	Forceps or vacuum delivery	____________________________________
YES or NO	Premature delivery	____________________________________
YES or NO	Did you experience any illnesses?	____________________________________
YES or NO	Did you nurse the baby?	____________________________________
YES or NO	Did the baby have colic?	____________________________________
YES or NO	Did you choose to vaccinate your child?	____________________________________

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

Is/Has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, hockey, baseball, wrestling, cheerleading, martial arts, etc…)? _____ If so, please list ___________________________
____

THE ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

New Patient Name (please print): ______________________________________ **Date** _____/_____/_____

New Patient Signature: ____

Signature of parent or legal guardian: __________________________________ **Date** _____/_____/_____