Confidential Patient Information

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Name: _____ Home Number: _____

Address: _____ Work Number: _____

City: _____ Postal Code: _____

Birth date: _____ Sex: _____ Weight: _____ Height: _____
D M Y

Names of Parents/guardians: _____ Referred by: _____

PURPOSE FOR CONTACTING US? _____

Other Doctors seen for the condition: Yes: _____ No: _____

Doctors names and prior treatments: _____

_____

Other health problems? _____

Family History: _____

Previous Chiropractor: _____

Date of Last Visit: _____ Reason: _____

Name of Family Doctor: _____

Date of Last Visit: _____ Reason: _____

Number of doses of antibiotics your child has taken: _____

During the past six months: _____ Total during lifetime: _____

Number of doses of other prescription medications your child has taken:

During the past six months: _____ List: _____

Total during lifetime: _____ List: _____

Vaccination History: _____

Prenatal History

Name of Obstetrician/Midwife: _____

Complications during pregnancy? ____ Y ____ N List: _____

Complications during delivery? ____ Y ____ N List: _____

Medications during delivery/pregnancy? ____ Y ____ N List: _____

Birth Intervention: ____ Forcepts ____ Vacuum Extraction
____ Cesarean Section - Emergency or Planned?

Location of Birth: ____ Hospital ____Other

Birth Weight: _____ Birth Length: _____

Feeding History

Breast Fed : ____ Y ____ N How Long?: _____
Formula Fed: ____ Y ____ N How Long?: _____ Type: _____

Food/juice allergies or intolerances? ____ Y ____ N List: _____

Developmental History

According to the National Safety Council, approximately 50% of children fall 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?
____ Y ___ N List: _____

Is/has your child been involved in any high impact or contact type sports (eg. soccer, football, gymnastics, baseball, martial arts, figure skating, etc.)? ____ Y ____ N
List: _____

Has your child ever been involved in a car accident? ____ Y ____ N
List: _____

Has your child been seen on an emergency basis? ____ Y ____ N
List: _____

Prior surgery? ____ Y ____ N List: _____

Adolescent History

Many childhood falls can create spinal misalignments that surface later in life. Has your child ever had a fall:

____ off a bicycle ____ off a skateboard ____ while in-line skating (rollerblading)

____ down stairs ____ off playground equipment or out of a tree

How does your child sleep? ____ Side ____ Stomach ____ Back

List Medications, Vitamins or Supplements: _____

Please check off any of the following symptoms experienced:

____ Headaches
____ Dizziness
____ Neck Pain
____ Tension across shoulder/between shoulder blades
____ Shoulder pain
____ Low back pain
____ "Growing Pains"
____ Knee pain
____ Ankle/foot pain
____ Numbness/tingling in arms/hands
____ Numbness/tingling in legs/feet
____ Stomach upset
____ Difficulty sleeping
____ Fatigue
____ Scoliosis
____ Allergies
____ Other List: _____

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 and charges by this office.

Signed: _____ Date: _____