



Welcome! Please complete this form and bring it to your first appointment.

PERSONAL / PARENTAL CONTACT INFORMATION		
Name:		Age:
Birth date:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other	
Address:	City:	Postal Code:
Home phone:	Cell phone:	Work phone:
E-mail address:		
Parents' names:		

How did you hear about our office? Website Internet Location Referral:

Has your child ever been to a chiropractor before? Yes No

Name of chiropractor:

City:

Date of last visit:

Duration and frequency of care:

BIRTH				
Duration of gestation:		Duration of birth:		
Location of birth:				
Assisted? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes: <input type="checkbox"/> forceps	<input type="checkbox"/> vacuum extraction	<input type="checkbox"/> C-section	<input type="checkbox"/> induced labour
Medications delivered to mother at birth?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what:	
Was the birth normal?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Complications:				
APGAR?	At birth:	After 5 min:		
Birth weight:		Birth length:		

GROWTH AND DEVELOPMENT			
Was the infant alert and responsive within 12 hours of birth?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Explain:			
Is the child's development following a normal pattern? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Explain:			
Do sleeping patterns seem normal to you?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Explain:			
Family history of health problems (cancer, diabetes, heart disease, etc.):			
Mother's side:		Father's side:	Siblings:

CHEMICAL STRESSORS			
Was the child breast-fed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How long?	
At what age was the child introduced to ...	Formula:	Type:	
Cow's milk:	Solids:	Type:	
Commercial baby food:	Type:		
Food Intolerance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:	
During pregnancy, did the mother ...	Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	Drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Take supplements?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	
Have an illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	
Take drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	
Have an ultrasound?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How many and medical reason:	
Have an invasive procedure? (Amniocentesis, CVS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	
Take antibiotics?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	Number of courses:
Have a vaccination?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	Reaction:
Have pets at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	
Have smokers at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How much?	
Has the child...			
Taken supplements?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	
Had an illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	
Taken antibiotics?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	
Had a vaccination?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	

PSYCHOSOCIAL STRESSORS			
Any difficulty with lactation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any problems with bonding? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Any behavioral problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	Onset:
Night terrors, sleepwalking, sleep trouble?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Explain:			
Does your child seem normal for their age?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Explain:			
Does your child experience high anxiety?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Explain:			

PHYSICAL STRESSORS		
Any evidence of birth trauma? Bruises, odd head shape, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, or other:		
Any trauma during pregnancy? (Falls, accidents, etc.)		
Any falls from couches, beds, or change tables?		
Any cuts, stitches, fractures, or bruises?		
Any hospitalizations?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:
Any surgeries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:

The **nervous system** controls and coordinates all of your body functions. **Chiropractic care** is designed to correct spinal misalignments that inhibit the nervous system, which in turn reduces body function. The following questions will help give us a complete picture of your child's health.

Check all conditions that your child has experienced or has been diagnosed with (past or present):

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Stomach Pain | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Unexplained Weight Loss | <input type="checkbox"/> Frequent Colds/Flus | <input type="checkbox"/> Bloody Stools/Urine | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Nausea or Vomiting |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Dysfunction | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Fever/Chills/Sweats | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Spitting Blood |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Fainting/Convulsions | <input type="checkbox"/> Waking to Urinate | <input type="checkbox"/> Tremors |

Check all other conditions that your child has experienced recently:

- | | | |
|--|--|-------------------------------------|
| <input type="checkbox"/> Irritable/Nervousness | <input type="checkbox"/> Sleeping Difficulty | <input type="checkbox"/> Low Energy |
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Poor Digestion | <input type="checkbox"/> Dizziness |

What would you like to gain from chiropractic care?

Any other concerns we should know about?

How can we make your experience in our office even better?

I, _____, give consent to receiving email reminders for my child's appointments.
Print Name

Signature

Date