

Date: \_\_\_/\_\_\_/\_\_\_

Child's Name \_\_\_\_\_ Birth Date \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Address \_\_\_\_\_

Street

City

State

zip code

Home Telephone # \_\_\_\_\_ Parents' Alternate Telephone # \_\_\_\_\_ (c), (w)

Email address \_\_\_\_\_

Who may we thank for referring your child to our office? \_\_\_\_\_

## YOUR HEALTH PROFILE

What brings your child to our office? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **Many spinal problems can come from the birth process itself. Please tell us about your child's delivery.**

Was your Child full term? \_\_\_\_\_ Premature? \_\_\_\_\_ How long? \_\_\_\_\_ Past expected due date? How long? \_\_\_\_\_

Birth Location – Home \_\_\_\_\_ Birthing Center \_\_\_\_\_ Hospital \_\_\_\_\_

Were Forceps \_\_\_\_\_ Vacuum Extraction \_\_\_\_\_ or a C-Section \_\_\_\_\_ necessary?

Is there anything else about the delivery you would like to tell us? \_\_\_\_\_

### **Feeding History**

Was your child breast fed? \_\_\_\_\_ For how long? \_\_\_\_\_

Was your child formula fed? \_\_\_\_\_ For how long? \_\_\_\_\_

At what age were solid foods introduced? \_\_\_\_\_

### **Possible Injuries**

Has your child been vaccinated at all? \_\_\_\_\_

Has your child ever experienced high fevers, seizures, unconsciousness, or inconsolable crying etc. following a vaccination? \_\_\_\_\_ Describe \_\_\_\_\_

50% of all children fall or are dropped from a high place during the first year of life. Has your child ever fallen from the bed, bunk bed, changing table, down the stairs, a tree, etc.? \_\_\_\_\_ Describe \_\_\_\_\_

Has your child ever been in the car with anybody during a collision, regardless of how minor? \_\_\_\_\_

Does your child play any contact sports? \_\_\_\_\_

### **History of Illnesses**

Does your child have a history of chronic ear infections? \_\_\_\_\_ how many in how long? \_\_\_\_\_

What treatments has (s)he received for this? Antibiotics \_\_\_\_\_ Tubes \_\_\_\_\_ Myringotomy \_\_\_\_\_ Other \_\_\_\_\_

Does the child have a history of chronic Tonsillitis? \_\_\_\_\_ If so, have the tonsils been removed? \_\_\_\_\_

Does the child have a history of Appendicitis? \_\_\_\_\_ If so, has the Appendix been removed? \_\_\_\_\_

Has your child had any other surgeries? \_\_\_\_\_

Has your child ever seen a Chiropractor before? Yes No If yes - Who? \_\_\_\_\_ Where? \_\_\_\_\_

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine my child for further evaluation. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date