Date: _____

Child's Name: _____ Mother's Name:_____

Prov. Healthcare # _____ Father's Name: _____

Address: _____ City: _____ Prov: ___ Postal Code_____

Home Phone:_____ Mother's Work: _____ Cell: _____

Email: _____ Father's Work: _____ Cell: _____

Who is responsible for this account?_____ Relationship to Patient:_____

Birth Date: _____ Age:____ Sex: __ M __ F Number of Siblings ___

Birth Weight: ____ lbs Current Weight: ____ lbs Referred by: _____

Purpose of this appointment: _____

Past Chiropractor: _____ (if applicable) Last seen: _____ Purpose: _____

Delivery/Birth History: _____

_____

_____

Presentation: ___ Vertex ___Breech ___ Transverse ___ Face/Brow

Type of Birth: ___ Vaginal ___ Forceps ___ Caesarean ___ Suction Cap or Vacuum

Location: ___ Home ___ Hospital ___ Birthing Center

Problems during pregnancy: _____

Problems during labor/delivery: _____

APGAR Scores: ___ ___ Was there presence at birth of __ Jaundice (yellow) __ Cyanosis (blue)

___ Congenital Anomalies/Defects? If yes, please explain _____

Infant Feeding ___ Breast (how many months? ___) ___ Bottle (which Formula? _____)

Number of hours sleeping per night ___ Quality of Sleep: ___ Good ___ Fair ___ Poor

Obstetrician/Midwife: _____

Pediatrician/Family MD: _____

Date of last visit: _____ Purpose: _____

Immunization History: _____

Number of doses of antibiotics taken: During past 6 months ____ During lifetime _____

Has your child ever been treated on an emergency basis? __ N __ Y If yes, explain, _____

_____

At what age did the child:

Respond to sound _____ Follow an object with her/his eyes _____ Hold head up _____
Sit alone _____ Crawl _____ Stand _____ Walk alone _____

At what age, if ever, did this child suffer from the following childhood diseases?

Chickenpox _____ Mumps _____ Measles _____ Rubella _____
Roseola _____ Whooping Cough _____ Other _____

Has this child ever suffered from:

__Headaches __Orthopedic Problems __Excessive gas __Behavioral Problems
__Dizziness __Neck Problems __Poor Appetite __ADD/ADHD
__Fainting __Arm/leg Problems __Stomach Aches __Ruptures/Hernia
__Seizures __Frequent Fevers __Reflux/vomiting __Muscle Pain
__Diarrhea __Joint Problems __Constipation __Growing Pains
__Earaches __Backaches __Heart trouble __Skin Rashes
__Diabetes __Sinus Trouble __Poor Posture __Difficulty concentrating
__Asthma __Scoliosis __Hypertension __Allergies_____
__Colds/flu __Walking Trouble __Anemia __ Allergies_____
__Colic __Broken Bones __Bed Wetting __Other_____
__Unexplained Irritability __Excessive Crying

Has this child ever suffered the following spinal traumas?

__Fall in baby walker __Fall from bed or couch __Fall off skateboard/skates/etc.
__Fall from crib __Fall off swing __Fall off bicycle
__Fall from highchair __Fall off monkey bars __Fall off slide
__Fall from changing table __Fall down stairs __Other_____

Has this child ever sustained an injury playing organized sports? ____ If yes, please explain____
_____

Has the child ever sustained injuries in an auto accident? ____ If yes, please explain_____
_____

Present Medical History: _____
_____

Surgery: _____
Medications: _____
Accidents: _____
Family Health History: _____
_____

Parent/Legal Guardian Signature: _____ Date: _____