

Child's Name:		Parent/Guardian:	
Street Address:		City, State, Zip:	
Cell Phone:		Other Phone:	
Email:		Gender:	Male Female
Birthdate:	___ / ___ / _____	Age:	_____ Months _____ Years
Height & Weight	_____ ft. _____ in. / _____ lbs	Who is primary care physician?	

List any drugs, medications, vitamins etc.? _____

Is your child receiving care from another healthcare provider? yes / no
 For what issue? _____

Current Health Conditions

Primary issue to address?	_____ _____ _____	When did the issue start?	_____ _____ _____
Has your child had this before?	Yes / No When: _____	Frequency?	Rare Intermittent Always
Is it getting worse?	Yes / No / Maybe		

Have you or your child ever seen a chiropractor before? Yes No If yes, why? _____

PREGNANCY & FERTILITY HISTORY: (Circle and explain if necessary)

Any fertility issues?	Yes No	If yes, please explain: _____
Did "mom" smoke or drink?	Yes No	If yes, please explain: _____
Did "mom" exercise?	Yes No	If yes, please explain: _____
Was "mom" ill? Morning sickness?	Yes No	If yes, please explain: _____
Any ultrasounds?	Yes No	If yes, please explain: _____
Any illnesses or infections while pregnant?	Yes No	If yes, please explain: _____

Any other comments regarding your pregnancy or fertility. _____

LABOR & DELIVERY HISTORY (Circle and explain if necessary)

Child birth was:	<i>Natural vaginal birth</i>	<i>Scheduled C-section</i>	<i>Emergency C-section</i>	Additional Info: _____ _____ _____ _____
Child birth was:	<i>At home</i>	<i>Birth center</i>	<i>Hospital</i>	
Please check if applicable:	<i>Breech</i>	<i>Induction</i>	<i>Pain meds</i>	
<i>Epidural</i>	<i>Episiotomy</i>	<i>Vacuum Extraction</i>	<i>Forceps</i>	

APGAR Score at birth: _____ APGAR after 5 minutes: _____

Birth weight: ___ lbs. ___ oz. Child's birth height: ___ inches

GROWTH & DEVELOPMENT HISTORY (Circle and explain if necessary)

Is/was your child breastfed?	Yes No	If yes, how long?	_____
Is/was breastfeeding difficult?	Yes No	If yes, explain.	_____
Does your child suffer from:	Colic	Reflux	Diarrhea / Constipation
Did/does your child frequently arch their neck/back, feel stiff, or bang their head?	Yes No	If yes, explain.	_____ _____
Have you chosen to vaccinate?	Yes No	Delayed schedule	Yes, on schedule / Religious exemption
Has your child been on antibiotics?	Yes No	If yes, explain.	_____ _____
Does your child have trouble sleeping?	Yes No	If yes, explain.	_____ _____
Behavioral, social or emotional issues?	Yes No	If yes, explain.	_____ _____
How would you describe your child's diet?	Organic	Gluten Free Dairy Free	_____ _____

Please list any food allergies or intolerances your child has: _____

Please list any major issues, accidents, falls and/or fractures your child has had in his/her lifetime.

Please list your child's hospitalization and surgical history: _____

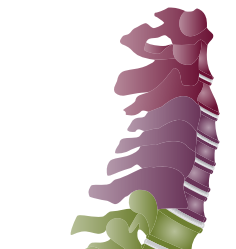
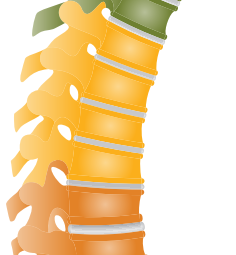

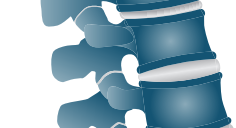
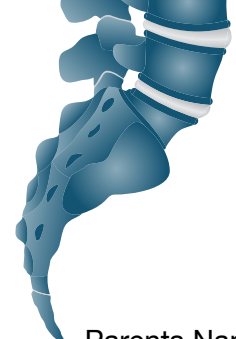
At what age did your child start the following activities?

Respond to sound:		Follow an object:		Begin solid foods:	
Hold their head up:		Vocalize:		Walk:	
Teethe:		Sit alone:		Crawl:	

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.

REGIONS	FUNCTIONS	SYMPTOMS	
 Cervical	<ul style="list-style-type: none"> Autonomic Nervous System ENT System Vision, Balance & Coordination Speech Immune System Digestive System Nerve Supply to Shoulders, Arms & Hands Sympathetic Nucleus Metabolism 	<input type="checkbox"/> PAST <input type="checkbox"/> PRESENT	<input type="checkbox"/> PAST <input type="checkbox"/> PRESENT
		Colic & Excessive Crying	Epilepsy & Seizures
		Ear & Sinus Infections	Sensory & Spectrum
		Allergies & Congestion	ADD / ADHD
		Immune Deficiency	Focus & Memory Issues
		Headaches & Migraines	Anxiety & Stress
		Vertigo & Dizziness	Balance & Coordination
		Sore Throat & Strep	Speech Issues
		Swollen Tonsils & Adenoids	TMJ / Jaw Pain
		Vision & Hearing Issues	Stiff Neck & Shoulders
Low Energy & Fatigue	Depression		
Difficulty Sleeping	High Blood Pressure		
Pain, Numbness & Tingling in Arms to Hands	Poor Metabolism & Weight Control		
 Upper Thoracic	<ul style="list-style-type: none"> Upper G.I. Respiratory System Cardiac Function 	<input type="checkbox"/> PAST <input type="checkbox"/> PRESENT	<input type="checkbox"/> PAST <input type="checkbox"/> PRESENT
		Reflux / GERD	Bronchitis & Pneumonia
		Chronic Colds & Cough	Functional Heart Conditions
 Mid Thoracic	<ul style="list-style-type: none"> Major Digestive Center Detox & Immunity 	<input type="checkbox"/> PAST <input type="checkbox"/> PRESENT	<input type="checkbox"/> PAST <input type="checkbox"/> PRESENT
		Gallbladder Pain / Issues	Indigestion & Heartburn
		Jaundice	Stomach Pains & Ulcers
 Lower Thoracic	<ul style="list-style-type: none"> Stress Response Filtration & Elimination Gut & Digestion Hormonal Control 	<input type="checkbox"/> PAST <input type="checkbox"/> PRESENT	<input type="checkbox"/> PAST <input type="checkbox"/> PRESENT
		Chronic Fatigue	Kidney Problems
		Chronic Stress	Gas Pain & Bloating
		Behavior Issues	Allergies & Eczema
 Lumbar, Sacrum & Pelvis	<ul style="list-style-type: none"> Lower G.I. (Absorption & Motility) Gut-Immune System Major Hormonal Control 	<input type="checkbox"/> PAST <input type="checkbox"/> PRESENT	<input type="checkbox"/> PAST <input type="checkbox"/> PRESENT
		Constipation	Sciatica & Radiating Pain
		Chrohn's, Colitis & IBS	Lumbopelvic / SI Joint Pain
		Diarrhea	Hamstring Tightness
		Bed-wetting	Disc Degeneration
		Bladder & Urination Issues	Leg Weakness & Cramps
		Cramps & Menstrual Issues	Poor Circulation & Cold Feet
		Cysts & Endometriosis	Knee, Ankle & Foot Pain
		Infertility	Weak Ankles & Arches
		Impotency	Lower Back Pain
		Hemorrhoids	Gluten & Casein Intolerance

Parents Name: _____

Signature: _____

Date: _____