

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: \_\_\_\_\_ S.S. #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Name of Parents/Guardians: \_\_\_\_\_

Referred By: \_\_\_\_\_

Purpose For Contacting us? \_\_\_\_\_

Other Doctors seen for this condition \_\_\_N\_\_\_Y

Doctor's Name: \_\_\_\_\_

Prior Treatments: \_\_\_\_\_

Other health problems? \_\_\_\_\_

Check any of the following conditions your child has suffered from during the past six months:

- Ear infections       Scoliosis       Seizures       Chronic Colds       Headaches
- Growing Pains       Colic       Asthma       Bed Wetting       Allergies
- Digestive Problems       Back Pains       Back Pains       Recurring Fevers       ADHD
- Temper Tantrums       Car Accident
- Other \_\_\_\_\_

Family History \_\_\_\_\_

Previous Chiropractor \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Reason: \_\_\_\_\_

Name of Pediatrician: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Reason: \_\_\_\_\_

Are you satisfied with the care your child has received there? \_\_\_N\_\_\_Y

Number of doses of antibiotics your child has taken: During the past six months: \_\_\_\_\_

Total during his/her lifetime: \_\_\_\_\_

Number of doses of other prescription medications your child has taken: During the past six months: \_\_\_\_\_, Total during his/her lifetime: \_\_\_\_\_

List medications: \_\_\_\_\_

Vaccination History: \_\_\_\_\_

### Prenatal History

Name of Obstetrician/Midwife: \_\_\_\_\_

Complications during pregnancy: \_\_\_N \_\_\_Y

If any complications please list: \_\_\_\_\_

Ultrasounds during pregnancy: \_\_\_N \_\_\_Y Number \_\_\_\_\_

Medications during pregnancy/delivery: \_\_\_N \_\_\_Y

Please list all medications during pregnancy/delivery: \_\_\_\_\_

Cigarette/alcohol use during pregnancy: \_\_\_N \_\_\_Y

Location of birth: \_\_\_ Hospital \_\_\_ Birthing Center \_\_\_ Home Birth

Intervention: \_\_\_ Forceps \_\_\_ Vacuum Extraction \_\_\_ Ceasarian Section

Emergency or Planned \_\_\_\_\_

Complications during delivery: \_\_\_N \_\_\_Y List: \_\_\_\_\_

Genetic disorders or disabilities: \_\_\_N \_\_\_Y List: \_\_\_\_\_

Birth weight: \_\_\_\_\_ Birth length: \_\_\_\_\_ APGAR Scores: \_\_\_\_\_, \_\_\_\_\_

### Feeding History

Breast Fed: \_\_\_N \_\_\_Y How long \_\_\_\_\_

Formula Fed: \_\_\_N \_\_\_Y How long: \_\_\_\_\_ Type: \_\_\_\_\_

Introduced to solids at: \_\_\_\_\_ months, cows' milk at \_\_\_\_\_ months

Food/juice allergies or intolerance: \_\_\_N \_\_\_Y

List food or juice allergies: \_\_\_\_\_

### Development History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

\_\_\_\_\_ Respond to Sound                      \_\_\_\_\_ Cross Crawl

\_\_\_\_\_ Respond to visual stimuli                      \_\_\_\_\_ Stand Alone

\_\_\_\_\_ Hold Head Up                      \_\_\_\_\_ Walk Alone

\_\_\_\_\_ Sit Up

PATIENT NAME \_\_\_\_\_ ACCOUNT # \_\_\_\_\_ DATE \_\_\_\_\_

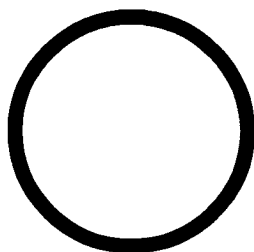
DEVELOPMENTAL ASSESSMENT (check all that apply)

- |              |   |  |
|--------------|---|--|
| 2 months     | <input type="checkbox"/> Keeps hands fisted             | <input type="checkbox"/> Smiles responsively               |
|              | <input type="checkbox"/> Lifts head for several seconds | <input type="checkbox"/> Begins to vocalize                |
| 3 months     | <input type="checkbox"/> Lifts head above body plane    | <input type="checkbox"/> Watches own hands                 |
|              | <input type="checkbox"/> Turns head toward object       | <input type="checkbox"/> Smiles and vocalized in response  |
| 4 months     | <input type="checkbox"/> Sits with head steady          | <input type="checkbox"/> Turns head toward sounds          |
|              | <input type="checkbox"/> Reaches for object             | <input type="checkbox"/> Smiles spontaneously              |
| 5-6 months   | <input type="checkbox"/> Lifts head while supine        | <input type="checkbox"/> Babbles                           |
|              | <input type="checkbox"/> Exhibits no head lag           | <input type="checkbox"/> Localizes direction of sound      |
| 7-8 months   | <input type="checkbox"/> Sits alone tripod fashion      | <input type="checkbox"/> Mouths all objects                |
|              | <input type="checkbox"/> Feeds self cracker             | <input type="checkbox"/> Non specific "dada", "baba"       |
| 9-10 months  | <input type="checkbox"/> Sits well without support      | <input type="checkbox"/> Waves "bye-bye"                   |
|              | <input type="checkbox"/> Stands holding on              | <input type="checkbox"/> Drinks from a cup with assistance |
| 11-12 months | <input type="checkbox"/> Walks with assistance          | <input type="checkbox"/> Uses 2-4 words with meaning       |
|              | <input type="checkbox"/> Crawls well                    | <input type="checkbox"/> Assists with dressing             |
| 13-15 months | <input type="checkbox"/> Walks by self; falls easily    | <input type="checkbox"/> "Dada/" "Mama" specific           |
|              | <input type="checkbox"/> Cruises                        | <input type="checkbox"/> Points to things wanted           |
| 18 months    | <input type="checkbox"/> Climbs stairs with assistance  | <input type="checkbox"/> Feeds self                        |
|              | <input type="checkbox"/> Throws ball                    | <input type="checkbox"/> Uses many intelligible words      |
| 24 months    | <input type="checkbox"/> Kicks ball                     | <input type="checkbox"/> Handles spoon well                |
|              | <input type="checkbox"/> Runs; climbs stairs along      | <input type="checkbox"/> Speaks 2-3 word sentences         |
| 30 months    | <input type="checkbox"/> Jumps                          | <input type="checkbox"/> Knows full name                   |
|              | <input type="checkbox"/> Walks on tiptoes               | <input type="checkbox"/> Recognizes three colors           |
| 36 months    | <input type="checkbox"/> Pedals tricycle                | <input type="checkbox"/> Walks up stairs alternating feet  |
|              | <input type="checkbox"/> Stands on one foot             | <input type="checkbox"/> Knows age and sex                 |
| 48 months    | <input type="checkbox"/> Throws ball overhand           | <input type="checkbox"/> Buttons large buttons             |
|              | <input type="checkbox"/> Climbs well                    | <input type="checkbox"/> Plays with several children       |
| 60 months    | <input type="checkbox"/> Skips                          | <input type="checkbox"/> Dresses and undresses             |

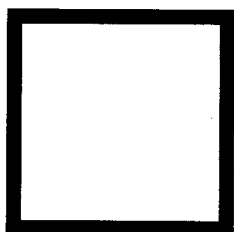
COGNITIVE DEVELOPMENT

Have the patient copy the following

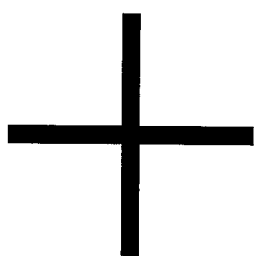
**Age 3**



**Age 4**



**Age 6**



According to the national safety Council, approximately 50% of children fall head first 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? \_\_\_ N \_\_\_ Y

Is/has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? \_\_\_ N \_\_\_ Y

Has your child ever been involved in a car accident? \_\_\_ N \_\_\_ Y List: \_\_\_\_\_

Has your child been seen on an emergency basis? \_\_\_ N \_\_\_ Y List: \_\_\_\_\_

Any other traumas not described above: \_\_\_ N \_\_\_ Y List: \_\_\_\_\_

Prior surgery: \_\_\_ N \_\_\_ Y List: \_\_\_\_\_

**Childhood Diseases:**

Chicken Pox \_\_\_ N \_\_\_ Y Age \_\_\_\_\_ Mumps \_\_\_ N \_\_\_ Y Age \_\_\_\_\_

Rubella \_\_\_ N \_\_\_ Y Age \_\_\_\_\_ Whooping Cough \_\_\_ N \_\_\_ Y Age \_\_\_\_\_

Rubeola \_\_\_ N \_\_\_ Y Age \_\_\_\_\_

Other \_\_\_ N \_\_\_ Y Age \_\_\_\_\_ Describe \_\_\_\_\_

**WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.**

**AUTHORIZATIONS 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 charged by this office.

Name of Insurance Company \_\_\_\_\_

Policy #: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Witnessed: \_\_\_\_\_

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