

Patient #: _____

C O M M U N I T Y

CHIROPRACTIC

PLEASE PRINT

Child's Full Name: _____ Date: _____

Parent #1 Name: _____ Parent #2 Name: _____

Parent #1 Home Phone: _____ Parent #2 Home Phone: _____

Parent #1 Phone Work or Cell: _____ Parent #2 Phone Work or Cell: _____

Parent #1 Email Address: _____ Parent #2 Email Address: _____

Child's Home Address: _____ City: _____ State: _____ Zip: _____

Purpose of the appointment today with the Dr. Maj: _____

ADOPTION INFORMATION

Child's Age When Adopted _____ Date of Adoption _____

Known Health History of Child _____

BIRTH INFORMATION

Birth Date _____ Gender _____ Birth Weight _____ Birth Length _____ Current Age of Child _____

Type of Birth: Vaginal ___ Forceps ___ Breech ___ Cesarean ___ Home ___ Birthing Center ___ Hospital ___

Were there any problems during pregnancy and/or labor? There is more space on next page for additional information.

Apgar Scores: _____ Jaundice (yellow) at Birth: _____ Cyanosis (blue): _____

Congenital Anomalies/Defects: _____

Infant Feeding: Breast ___ Bottle ___ Formula ___ Other Food or Drink Information: _____

No. of Hours Child Sleeps Daily _____ Quality of Sleep: Good ___ Fair ___ Poor ___

Explain: _____

Number of Siblings _____ Name(s), Age(s) and Gender(s) _____

HEALTH AND MEDICAL INFORMATION

Obstetrician and/or Midwife Name: _____ Location: _____

Pediatrician and/or Family MD Name: _____ Location: _____

Date of Last Visit to Dr: _____ Purpose of that Visit: _____

Immunization History: _____

Has your child ever been treated on an emergency basis? _____ Please Describe: _____

Pregnancy History: _____

Delivery/Birth History: _____

Developmental History – At What Age Did the Child:

Respond to Sound _____
Crawl _____
Follow an Object with their Eyes _____
Hold Head Up _____
Stand _____
Sit Alone _____
Walk Alone _____

Childhood Diseases – Age of the Child When Occurred:

Chicken Pox _____
Rubella _____
Rubeola _____
Whooping Cough _____
Mumps _____
Measles _____
Other _____

Has this child ever suffered from (please check any that apply):

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Neck Problems |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Backaches | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Allergies | <input type="checkbox"/> Orthopedic Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Sugar Concentration | <input type="checkbox"/> Headaches | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Leg Problems |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Joint Problems |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Colds/Flu |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Muscle Jerking | <input type="checkbox"/> Ruptures/Hernias | <input type="checkbox"/> "Growing Pains" |
| <input type="checkbox"/> Any Other Problem | | | |

Present Health History or Additional Information: _____

Surgery Information: _____

Medications: _____

Accidents: _____

Family Health History: _____

AUTHORIZATION FOR CARE OF A MINOR

I HEREBY AUTHORIZE THIS CLINIC AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR GUARDIAN).

PARENT/GUARDIAN SIGNATURE(S): _____

DATE _____