Patient #: _____

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FUNCTIONAL HEALTH
COUNSELING • CHIROPRACTIC • NUTRITION

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: _____

How did you hear about Community Chiropractic? If someone referred you, what is their name? _____

Purpose of the appointment today: _____

_____

_____

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):

- ☐ Diabetes
- ☐ Fainting
- ☐ Dizziness
- ☐ Asthma
- ☐ Sugar Concentration
- ☐ Sleeping Problems
- ☐ Diarrhea
- ☐ Arm Problems
- ☐ Arthritis
- ☐ Behavioral Problems
- ☐ Bed Wetting
- ☐ Tuberculosis
- ☐ Stomach Aches
- ☐ Walking Problems
- ☐ Headaches
- ☐ Digestive Disorders
- ☐ Constipation
- ☐ Hyperactivity
- ☐ Neuritis
- ☐ Muscle Jerking
- ☐ Convulsions
- ☐ Backaches
- ☐ Allergies
- ☐ Rheumatic Fever
- ☐ Blood Disorders
- ☐ Sinus Trouble
- ☐ Paralysis
- ☐ Chronic Earaches
- ☐ Anemia
- ☐ Ruptures/Hernias
- ☐ Neck Problems
- ☐ Heart Trouble
- ☐ Orthopedic Problems
- ☐ Hypertension
- ☐ Broken Bones
- ☐ Leg Problems
- ☐ Joint Problems
- ☐ Colds/Flu
- ☐ Poor Appetite
- ☐ “Growing Pains”
- ☐ 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 CLINC 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 _____