



It's all about your child's uniqueness!

PATIENT INFORMATION

Patient Name _____ Parent(s)/Guardian(s) Name _____ Date _____

DOB _____ Age _____ Male _____ Female _____

Address _____ City _____ State _____ Zip _____

Home # _____ Office # _____ Cell # _____

Where do you prefer to receive calls? _____ Home _____ Office _____ Cell _____ No preference _____

Email _____

Have you or your child ever had chiropractic care before? Yes No

If yes, please tell us the doctor's name _____

How did you find out about our office? _____

Is your child receiving care from another health professional? Yes No

If yes, please name them and their specialty _____

Please list any drugs or medication your child is taking _____

Please list any allergies your child has _____

Please list any surgeries your child has had _____

Present Health Challenge(s):

What health challenge brings your child into the clinic today?

When did the symptoms first begin? _____

How did the problem start? Suddenly Gradually Post- injury

Is this condition: Getting Worse Improving Intermittent Constant Not Sure

Children 2 & under

Has the child received any antibiotics? Yes No If yes, how many times and list reason _____

Any difficulty with breastfeeding? Yes No If yes, please explain _____

Any difficulty with bonding? Yes No If yes, please explain _____

Any behavioral problems? Yes No If yes, please explain _____

Any night terrors, sleepwalking or difficulty sleeping? Yes No If yes, please explain _____

Average number of hours of TV/ iPad/screen time per week _____

Does your child have any other of the below health concerns?

<input type="checkbox"/> Allergies	<input type="checkbox"/> Frequent colds/ Congestion/Flu	<input type="checkbox"/> Seizures or epilepsy	<input type="checkbox"/> Asthma
<input type="checkbox"/> Ear infections	<input type="checkbox"/> Infected/sore Throat	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Cough/ Croup Bronchitis
<input type="checkbox"/> Headaches	<input type="checkbox"/> Reflux/GERD	<input type="checkbox"/> Urinary tract Infections	<input type="checkbox"/> Poor appetite/ Stomach Ulcer
<input type="checkbox"/> Poor digestion/ (constipation/diarrhea)	<input type="checkbox"/> Heart Disease, High Blood Pressure	<input type="checkbox"/> Eczema/psoriasis/ Other skin rashes	<input type="checkbox"/> ADD/ADHD/SPD
<input type="checkbox"/> Irregular sleep Patterns	<input type="checkbox"/> Arthritis-Rheumatoid, psoriatic...	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Speech issues
<input type="checkbox"/> Anxiety/Depression	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Cancer or Tumors	<input type="checkbox"/> Overweight

Your child's potential is limitless.

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Name _____ Date _____

Guardian Signature _____ Date _____