PEAK POTENTIAL
FAMILY CHIROPRACTIC

www.TheWoodlandsChiro.com

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_____

Cell # _____ ○ Opt-in to receive text about appointment details

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?

____ Allergies	____Frequent colds/ Congestion/Flu	____Seizures or epilepsy	____Asthma
____Ear infections	____Infected/sore Throat	____Tonsillitis	____Cough/ Croup Bronchitis
____Headaches	____Reflux/GERD	____Urinary tract Infections	____Poor appetite/ Stomach Ulcer
____Poor digestion/ (constipation/diarrhea)	____Heart Disease, High Blood Pressure	____Eczema/psoriasis/ Other skin rashes	____ADD/ADHD/SPD
____Irregular sleep Patterns	____Arthritis-Rheumatoid, psoriatic…	____Bed Wetting	____Speech issues
____Anxiety/Depression	____Mood swings	____Cancer or Tumors	_____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_____