HEALTH, WELLNESS AND PEDIATRIC CHIROPRACTIC CARE

Please fill out this form as completely and accurately as possible.

Today's Date_____

PERSONAL DATA

Child's Name_____ Age _____ Date of Birth _____

Parent's names _____

Home Address_____ City _____ State_____ Zip _____

Home phone (____) _____ Parent's Business Phone (____) _____

Cell Phone (____) _____Parent's E-mail address_____

Parent's Occupation_____Parent's Employer _____

SS# (opt'l)_____ Emergency contact _____

Marital Status of Parent ❑ S ❑ M ❑ D ❑ W ❑ L/W

Names and Ages of Child's Siblings:_____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Denette Family Chiropractic can address for your child?

_____

Are these concerns affecting your child's quality of life? (Please circle only those applicable to your child)

School:	Y	N	Sleep:	Y	N	Walking:	Y	N
Sitting:	Y	N	Exercise/sports:	Y	N	Eating:	Y	N

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received Chiropractic care? ❑Y ❑ N Name of D.C._____

How long under care? ❑ _____days ❑_____weeks ❑_____ months ❑ years_____

Date of last visit: _____Why did you stop?_____

_____

Have you consulted or do you regularly consult any of the following providers for your child?

❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath

❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Dentist

Reason why: _____

PREGNANCY

Name of Obstetrician/Midwife: _____

Were there any complications to the pregnancy? _____

Was Mom on any medications, prescription or over-the-counter? ❒ Yes ❒ No If yes, please explain: _____

_____

How many ultrasounds were performed _____

Did Mom or Dad smoke during pregnancy? ❒ Yes ❒ No Who? _____

Did Mom consume alcohol during pregnancy? ❒ Yes ❒ No Type and amount of alcohol: _____

LABOR AND DELIVERY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please indicate where and how your baby was birthed. (If you do not know, please skip to next question)

❑ Home ❑ Natural ❑ Hospital ❑ Caesarian section ❑ Forceps
❑ Breech ❑ Cord around neck ❑ Prolonged labor ❑ Drug induced labor ❑ Vacuum Extraction

If the delivery was by Caesarian section, was it: ❒ Emergency ❒ Planned
Were there complications during the delivery? _____
How long was the labor? _____ How long was the delivery? _____
Medications used during labor or delivery: _____

INFANCY

Was your child vaccinated? ❒ Yes ❒ No If yes, did your child have a reaction? ❒ Yes ❒ No
If yes, what was the reaction that occurred? _____
Was there any use of medications during infancy? ❒ Yes ❒ No
If yes, which medications were used, and for what?_____
How long was your baby on these medications?_____

According to the Nation 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 infant? ❒ Yes ❒ No
If yes, please describe:_____
_____
Did the infant suffer any other traumas such as car accidents or abuse? _____
_____

Was your child breast fed? ❒ Yes ❒ No If yes, for how long? _____
Did your child prefer one breast over another? ❒ Yes ❒ No Which breast? ❒ R ❒ L
Was your child formula fed? ❒ Yes ❒ No How long? _____ Type: _____
What month was your child introduced to solids? _____
Does your child have any food/juice allergies or intolerances? ❒ Yes ❒ No List: _____
_____

At what month was your child able to: ____ Hold head up ____Sit Up ____Cross Crawl
____ Stand alone ____ Walk Alone

CHILDHOOD

Has your child had any **accidents or injuries** related to any of the following? (check all that apply)

❑ Automobile ❑ Falls ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If yes, state ***type of injury and date:***
_____
_____

Is your child taking any prescription medications? ❒ Yes ❒ No For what: _____

How many doses of antibiotics has your child taken: During the past 6 months _____, Total lifetime: _____

Is your child involved in any high impact or contact sports (i.e. soccer, football, gymnastics, etc.)? _____

Is there anything else you think we should know about your child? _____

The information I have provided, on this case history form, is true and accurate, to the best of my knowledge. I give Daniel Denette, D.C and Kristen Denette, D.C. permission to render care to my child. This initial visit includes a health history/consultation, chiropractic exam/evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Signature of Parent:_____ Today's Date_____