

## Infant Chiropractic Information

(< 14 years old)

Date: \_\_\_\_\_

Name:	Date of birth (Month/Day/Year):
	Please circle sex:    Male    Female
Home Address and Phone Number:	Names of parents or guardians:
E-mail:	
Family Medical Doctor:	Referred by: <input type="checkbox"/> Friend/Family <input type="checkbox"/> M.D. / D.C. <input type="checkbox"/> Internet/Add
Name and ages of other children:	Work Number:

**Why this form is important:**

Our office focuses on your child's ability to be healthy. Our goals are to first address the issues that brought you and your child to this office, and second, offer the opportunity to improve your child's health potential in the future. Life activities include events that cause damage. This damage builds layer upon layer even to levels at which you may **not yet be aware**.

Research is showing that many of the health challenges that occur later in life have their origins during the developing years, some starting at or before birth. We need to know what your child's layers of damage contain, so we ask you to carefully and completely fill out this detailed and important form.

**Labour and Delivery**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Hospital with doctor                  | <input type="checkbox"/> Hospital with Midwife | <input type="checkbox"/> Home with Midwife         |
| <input type="checkbox"/> Breach                                | <input type="checkbox"/> Caesarian             | <input type="checkbox"/> Fetal Monitor Used        |
| <input type="checkbox"/> Medications                           | <input type="checkbox"/> Forceps               | <input type="checkbox"/> Length of delivery: _____ |
| <input type="checkbox"/> Complications. Please describe: _____ |  |  |

Name of Midwife: \_\_\_\_\_

**Prenatal & Infant History**

Number of Ultrasounds given during pregnancy: \_\_\_\_\_

Duration of pregnancy in weeks: \_\_\_\_\_      APGAR Score at birth: \_\_\_\_\_

Birth Length: \_\_\_\_\_      Birth Weight: \_\_\_\_\_

Please check any problems the patient had at birth:

- |                                       |                                   |                                  |
|---------------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Jaundice     | <input type="checkbox"/> Cyanosis | <input type="checkbox"/> Choking |
| <input type="checkbox"/> Other: _____ |                                   |                                  |

Please check if any of the following applied to the patient after birth (up to today):

Medication                       Artificial Feeding                       Vitamin K  
 Surgery                               Erythromycin                               Circumcision  
 Other: \_\_\_\_\_

**Nutrition**

Please check if the patient received any of the following (up to today):

Breast Milk                       Commercial Formula                       Cow's Milk  
 Goat's Milk                       Solid Food                               Sweets  
 Fruit Juice                       Vitamins                               Medication  
 Other: \_\_\_\_\_

**Please list any medication take (prescription and/or over the counter):** \_\_\_\_\_

**Developmental History**

If your child is younger than 2, please indicate which of the following milestones s/he has reached:

Hold head up       Sits up       Crawls       Stands alone       Walks alone

According to National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (ie, bed, changing table, down stairs, etc). Was this the case with your child?

Yes  No Please describe the circumstances: \_\_\_\_\_

Has your child ever been involved in any high impact or contact type sports (ie, soccer, football, hockey, gymnastics, baseball, martial arts, etc?)  Yes  No Please list: \_\_\_\_\_

Has your child ever been treated on an emergency basis?  Yes  No. Please describe: \_\_\_\_\_

Other injuries or falls not described above?  Yes  No Please list: \_\_\_\_\_

Prior surgery?  Yes  No Please list: \_\_\_\_\_

Onset of first menstrual period: \_\_\_\_\_

Is your child vaccinated or have you chosen not to vaccinate? If you child has been vaccinated, please list any reactions: \_\_\_\_\_

**Childhood Diseases:** Has your child had any of the following illnesses? (please indicate age if applicable)

Measles (Rubeola) \_\_\_\_\_       Mumps \_\_\_\_\_       Rubella (German Measles) \_\_\_\_\_  
 Pertussis (Whooping Cough) \_\_\_\_\_       Chicken pox \_\_\_\_\_       Other \_\_\_\_\_

**Other Health Concerns:**

**Important Note:**

Chiropractic has helped children with many health problems like asthma, allergies, bed-wetting (nocturnal enuresis), colic, ear infections (acute and chronic), headaches, scoliosis, etc. Chiropractic care has also been shown to help prevent these and other illnesses from occurring and ensure children have a healthier life. To optimally prevent these, a child should have a chiropractic spinal exam as soon as they are born. Therefore it is important to get your other children's spines checked if they have not been checked.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. I have been informed of the Clinic's financial policy and agree that I am responsible for all bills incurred at this office

Patient/ Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## A word about our financial policies:

Our recommendations are based solely on the difficulty of your case and are never influenced by your level of insurance coverage.

All charges will be discussed with you and agreed upon, before any service will be provided.

Payment is expected on the day services are rendered unless other arrangements have already been agreed upon.

Practice members who are committed to their care programs will never be denied treatment. We have many programs which make our care affordable to those who are committed to achieving optimal health.

PLEASE ANSWER ALL QUESTIONS! Please print clearly.

1. Who is responsible for this account? \_\_\_\_\_

2. Relationship to practice member  
\_\_\_\_\_

3. Do you have insurance coverage? -  
\_\_\_\_\_

a. If yes, subscriber's name

\_\_\_\_\_

b. Date of birth \_\_\_\_\_ c. Social Security number

4. Do you have secondary coverage?  
\_\_\_\_\_

a. If yes, subscriber's name

\_\_\_\_\_

b. Date of birth \_\_\_\_\_ c. Social Security number

5. **How would you like to pay for your 1st visit?** Please circle one

- a. Cash      b. Check      c. Credit Card  
d. Debit Card w/Visa,MC, Discover, AmEx.

PATIENT'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_