Personal Information

Child's First Name: ____________________ Last Name:______________________ M.I.____
Parent(s) Name(s): ____
Address: ____
City:_____________________________ State:______________ Zip:_______________
Phone #: __________________________ Work #:_______________________________
Email: ____
Child's Birth Date : _____/______/______ Child's Sex: M / F
Siblings Names: _____________________________ Age: ________ M / F
_____________________________ Age: ________ M / F
_____________________________ Age: ________ M / F
Parent(s) Occupation(s): ____
____
Who can we thank for referring you to our office? _______________________________________

Reason For Child's Care

What is your primary reason for seeking care? ____
____
When did this begin? ____ Suddenly / Gradual
What did you first notice? ____
____
Any major injuries and/or surgeries we should know about? _______________________________
____
What is this affecting that is MOST important to your child's life? __________________________
____
Has your child seen a chiropractor before? Yes No
How long ago? _____________________ Clinic/Doctor Name: ______________________________
Names/Specialties of other providers or care physicians for your child:
____
____
____
Describe your child, including his/her history. Please be as detailed as possible:
____
____
____
Please note any other event, action, etc. you think may have some bearing/relationship to your child's condition: ____
____
____

Prenatal History

Location of birth: Home Birthing Center____________ Hospital:__________ Other: _________
Maternal age at delivery: ______________
Did any of the following happen during delivery:
__ C-section delivery __Doctor pulled/twisted baby __Anesthesia __ Labor was induced
__ Forceps/vacuum extraction __ Premature delivery (_____weeks) __ Special medical procedures/tests
__ Full term delivery (_____weeks)
Any other complications during delivery: ____
Medications during labor/delivery: ____
Illnesses during pregnancy? Yes No if yes, explain: ____________________________________
Medications during pregnancy? Yes No if yes, explain: __________________________________
Any complications during pregnancy? Yes No if yes, explain:______________________________
Any complications after pregnancy? Yes No if yes, explain: _____________________________
Medications given to child at hospital: Yes No if yes, explain: ___________________________
Did you breastfeed the baby? Yes No if yes, how long: _________________________________
Did you formula-feed the baby? Yes No if yes, how long: _______________________________
Age which you introduced: Solids: ________________ Cow's Milk: _____________________

Lifestyle Habits

Any allergies? Yes No if yes, explain: ____
Suspected food allergies/sensitivities: Yes No if yes, explain: ______________________________
Select the foods most commonly in your child's diet:
__ dairy (milk / yogurt / cheese) __ carbohydrates (bread / pasta / cereal)
__ meat (chicken / fish / red meat) __ vegetables (potato / greens / carrots)
__ fruits (banana / apple / berries) __ snacks/sugary foods and/or drinks
Does your child exercise daily? Yes No How much: ____________________________________
Does your child have difficulty sleeping? Yes No explain: _______________________________
Does your child have positive self-esteem or self-image? Yes No

Health Status

Medications the child currently takes: ____
Supplements the child currently takes: ____
Please put an X by any other health concerns:

__ Anxiety/Depression
__ Constipation/Diarrhea
__ Nausea/Vomiting
__ Ear Infections
__ ADD/ADHD
__ Diabetes
__ Fatigue/Sleep Issues
__ Asthma/Bronchitis
__ Colic/Acid Reflux
__ Frequent Sickness
__ Learning Disorders
__ Back/Neck Pain
__ Sinus Troubles/Allergies
__ Autism/Asperger's
__ Overweight
__ Headaches
__ Difficulty Gaining Weight
__ Bed Wetting

Explain the selected health concerns: ____
____

Health Status Continued

Select if your child has ever done any of the following:

__ Fall in baby walker	__ Fall from bed/couch	__ Fall from crib
__ Fall off swing	__ Fall off bicycle	__ Fall from high chair
__ Fall off slide	__ Fall down stairs	__ Fall off changing table\
__ Fall off monkey bars	__ Fall off skateboard/skates	__ Walking difficulties
__ Broken bones	__ Been in a car accident	__ Plays contact sports

Explain the selected instances: ____

____

Has your child received all recommended vaccinations? Yes No Explain:_________________

____

Please list any other history, pertinent thoughts or questions that you want addressed:____________

____

____

____

On a scale of 1-10, ten being the highest, rate your commitment to correcting your child's health issues? _____________.

I understand that I am directly and fully responsible to Impact Chiropractic for all fees associated with chiropractic care my child receives. The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

____ _____________

Parent or Legal Guardian's Signature Date

____ _____________

Doctor's Signature Date