IMPACT CHIROPRACTIC family health center

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 Infant 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: _____
_____
_____

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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: _____

Health Status

Medications the child is on currently: _____
Supplements the child is on currently: _____
Please put an X by any other health concerns:

__ Sleep Issues	__ Difficulty Latching	__ Difficulty Gaining Weight
__ Constipation/Diarrhea	__ Autism/Disability	__ Frequent Sickness
__ Vomiting	__ Colic/Acid Reflux	__ Ear Infections

Explain the selected health concerns: _____
_____
Has your child received all recommended vaccinations? Yes No Explain:_____
_____
Please list any other history, pertinent thoughts or questions that you want addressed:_____
_____

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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