Dr. Fawn Shaffer, DC
565 McElhattan Drive
Lock Haven, PA 17745
(570) 748-3590

YOUTH (0-5 YEARS OLD) INFORMATION: Male Female

Child's Name: _____ Nickname: _____

Age: _____ DOB: _____

Mother's Name: _____ Father's Name: _____

Address: _____ City/State/ Zip: _____

Home Phone: (_____) _____-_____ Mom's Cell Phone: (_____) _____-_____

Dad's Cell Phone: (_____) _____-_____ Email: _____

Which Phone Number is Best to Contact? ***HOME*** ***MOM*** ***DAD*** Best Time to Contact: _____

Email Address: _____ School _____ Grade: _____

Number of Siblings: _____ Names & Ages: _____

Whom May We Thank For Referring You? _____

If You Weren't Referred, How Did You Hear About Our Office? _____

INSURANCE INFORMATION:

Do you have insurance? **YES** **NO** If so, please choose: BC/BS Other_____

Policyholder's Name _____ Date of Birth _____

"It is easier to build strong children than to repair broken adults."

~ Frederick Douglass

GENERAL INFORMATION:

BIRTH WEIGHT: _____ BIRTH LENGTH: _____ CURRENT WEIGHT: _____ CURRENT LENGTH/HEIGHT:_____

THIRD TRIMESTER PRESENTATION: *Vertex Breech Transverse Face/Brow*

TYPE OF BIRTH: *Normal Vaginal Forceps Cesarean Suction Cup/Vacuum*

Problems During Pregnancy or Labor/Delivery: _____

INFANT FEEDING: *BREAST BOTTLE* **If Bottle, Which Formula?** _____

Number of Hours Sleeping per Night: _____ **Quality of Sleep**: *GOOD FAIR POOR*

Who was the Obstetrician/Midwife? _____

Who is the child's Pediatrician? _____

Date of Last Visit? _____ **Reason?** _____

Is the child vaccinated? *YES NO*

How many times has the child been on antibiotics in the past 6 months? _____ **During his/her lifetime?** _____

PLEASE CHECK ANY OF THE FOLLOWING ISSUES THIS CHILD HAS EVER SUFFERED FROM:

	HEADACHES		BROKEN BONES
	DIZZINESS		DIGESTIVE DISORDERS
	FAINTING		POOR APPETITE
	SEIZURES/CONVULSIONS		STOMACH ACHES
	HEART TROUBLE		REFLUX
	CHRONIC EARACHES		CONSTIPATION
	SINUS TROUBLE		DIARRHEA
	ASTHMA		DIABETES
	COLDS/FLU		HYPERTENSION
	COLIC		ANEMIA
	ORTHOPEDIC PROBLEMS		BED WETTING
	NECK PROBLEMS		BEHAVIORAL PROBLEMS
	ARM PROBLEMS		ADD/ADHD
	LEG PROBLEMS		RUPTURES/HERNIA
	JOINT PROBLEMS		MUSCLE PAIN
	BACKACHES		GROWING PAINS
	POOR POSTURE		WALKING TROUBLE
	SCOLIOSIS		OTHER:

Does the child have any known allergies? *YES NO*

If Yes, Please List: _____

HAS THIS CHILD EVER SUFFERED FROM ANY OF THE FOLLOWING TRAUMAS?

	FALL IN BABY WALKER		FALL OFF SLIDE
	FALL FROM CRIB		FALL OFF MONKEY BARS
	FALL FROM HIGHCHAIR		FALL OFF SKATEBOARD OR SKATES
	FALL FROM CHANGING TABLE		FALL OFF BICYCLE
	FALL FROM BED OR COUCH		FALL DOWN STAIRS
	FALL OFF SWING		OTHER:

HAS THIS CHILD EVER SUSTAINED AN INJURY PLAYING ORGANIZED SPORTS? *YES NO*

IF YES, PLEASE EXPLAIN: _____

HAS THIS CHILD EVER SUSTAINED INJURIES IN AN AUTO ACCIDENT? *YES NO*

IF YES, PLEASE EXPLAIN: _____

HAS THIS CHILD HAD ANY SURGERIES? *YES NO*

IF YES, PLEASE LIST WITH DATES: _____

IS THIS CHILD ON ANY MEDICATIONS? *YES NO*

IF YES, PLEASE LIST: _____

**** WHY ARE YOU BRINGING YOUR CHILD IN FOR TODAY'S APPOINTMENT? ****

_____

_____

HAS THE CHILD SEEN A CHIROPRACTOR BEFORE? *YES NO*

IF SO, WHO? _____ DATE OF LAST VISIT? _____

****

AUTHORIZATION FOR CARE OF A MINOR

I HEREBY AUTHORIZE THIS OFFICE AND THE DOCTOR TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR GUARDIAN)

I ACKNOWLEDGE THAT ANY INSURANCE THE CHILD MAY HAVE IS AN AGREEMENT BETWEEN THE CARRIER AND THE POLICYHOLDER AND THAT I AM RESPONSIBLE FOR THE PAYMENT OF ANY COVERED AND NON-COVERED SERVICES THE CHILD RECEIVES

SIGNED: _____ DATE: _____

WITNESSED: _____ DATE: _____