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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? _____

"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)

SIGNED: _____ **DATE:** _____

WITNESSED: _____ **DATE:** _____

Please initial your agreement to the following statements and then sign below:

_____ I instruct the chiropractor to deliver the care that, in her professional judgement, can best help the child in the restoration of his/her health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

_____ I may request a copy of the Privacy Policy and understand it describes how the child's personal health information is protected and released on his/her behalf.

_____ I grant permission to be called to confirm, reschedule or discuss appointments and to be sent occasional cards, letters, emails or health information as an extension of the child's care in this office.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of the child's health concern.

Signature _____ **Date:** _____