Name: _____ Phone: (C) _____ (W) _____
Parents/ Guardians: _____ Birth Date: _____ (Age _____)
_____ Sex: _____ Weight:_____ Height:_____
Address: _____ Referred By: _____
City: _____Prov_____ PC_____ Email Address: _____

Chiropractic History

Have you previously seen a chiropractor? ☐ Yes ☐ No Reason _____ Did they take x-rays? ☐ Yes ☐ No
If yes, when was your last visit and how long did you receive care_____

Main concern for today's visit: _____
Pain or problem started on_____ Why do *you* think it started? _____
Does anything make it worst? ☐ Yes ☐ No _____
Does anything make it better? ☐ Yes ☐ No _____
Is it worse during certain times of the day? _____ Is it progressively getting worse? ☐ Yes ☐ No
Other Doctors seen: _____ Any home remedies? _____

Check any of the following conditions your child has suffered from during the past six months:

☐ Difficult Breastfeeding ☐ Ear Infections ☐ Seizures ☐ Chronic Colds ☐ Headaches ☐ Asthma / Allergies ☐ ADHD / ADD
☐ Digestive Problems ☐ Recurring Fever ☐ Growing / Back Pains ☐ Colic ☐ Bed Wetting ☐ Temper Tantrums ☐ Scoliosis
☐ Difficulty Sleeping ☐ Other _____

Medical History

Pediatrician: _____ Date of Last Visit: _____ Reason: _____
Vaccination History: _____
Antibiotics or other prescription history: _____ In the last six months: _____
Family medical conditions/history: _____

Childhood Diseses:

Chicken Pox: Age ____ N/A Measles: Age____ N/A Mumps: Age____ N/A Rubella: Age ____ N/A
Whooping Cough: Age ___ N/A Rubeola: Age ____ N/A Other_____ Age:____

Prenatal History:

Name of Obstetrician / Midwife: _____ Location of Birth: ☐ Hospital ☐ Birthing Center ☐ Home
Birth Weight: _____ Birth Length: _____ APGAR Scores: _____ , _____
Complications during pregnancy? ☐ Yes ☐ No What Type: _____
Cigarette / Alcohol / Drug use during pregnancy? ☐ Yes ☐ No
Medications during pregnancy / delivery? ☐ Yes ☐ No What Type: _____
Birth Interventions: ☐ Forceps ☐ Vacuum Extraction ☐ Caesarian Section (☐ Emergency ☐ Planned)
Complications during delivery? ☐ Yes ☐ No What kind: _____
Genetic disorders or disabilities? ☐ Yes ☐ No What type: _____

Feeding History:

Breast fed: ☐ Yes ☐ No How long: _____ Formula fed: ☐ Yes ☐ No How long: _____
Introduction to solids at: _____ months cows' milk at _____ months
Food allergies or intolerances: ☐ Yes ☐ No List: _____

Developmental History:

At how many months was your child able to: ____ Respond to sound, ____ Respond to visual stimuli, ____ Hold head up
____ Sit up unassisted, ____ Cross crawl, ____ Stand alone, ____ Walk alone.
Do you have any developmental concerns? _____

Accident/Trauma/Injury History:

Car accidents: ☐ Yes ☐ No How many: _____ Approximate dates: _____
Other traumas/accidents/injuries: ☐ Yes ☐ No What kind: _____
Surgeries: ☐ Yes ☐ No ☐ What type? _____ When? _____

Any other concerns? _____
_____

Signature _____ Date _____

MOMMY & ME FAMILY CHIROPRACTIC