Welcome to Freedom Chiropractic Health Center

should require any a		.					
Patient Information							
Child's Name:				Nickname?			
Child's Name: Male/Female:	Age:	Birthday:		Weight:	He	eight:	
Address:				City/State/Zip:			
Names and ages of	siblings:						
Parent/Guardian In							
Name(s):							
Address (if different				 _			
Home Phone Number	er:		Cell Pho	ne Number:			
Parent's Occupation							
Insurance Informat	<u>ion</u>						
Who is responsible f	or this account?			Relationshi	p to patient:		
Insurance Co:							
Subscriber's Name:			Subs	criber's SS#:			
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About Your Child

The Pregnancy Process During pregnancy, did the mother: Take Medication?_____ If yes, what type?_____ Drugs?____ Describe:_____ Take supplements? ____ List: ______ Undergo a lot of stress? ______ Receive ultrasound or other radiation? _____ If yes, how many? _____ Medical reason? ______ Have problems with the pregnancy? If yes, describe: The Birthing Process Birth Location: Hospital Birthing Center Home Birth Assistants: Doctor Midwife Doula Type of Birth: Vaginal Forceps Vacuum/Suction Induced C-section (circle one): planned / emergency Baby Presentation at Birth (or 3rd trimester:) Head first (cephalic) Breech Posterior (facing forward) Transverse Did the mother: (check all that apply) Take Medication, type______ Have an epidural Episiotomy How long was labor? _____ Were there complications?_____ What was the mother's position during labor?______ Who else was present? Did the birth assistant twist or pull the baby during birth? (explain)___ What was the child's gestational age at birth?______ Birth Weight:_____ Length:_____ APGAR Score at Birth:_____ After 5 minutes: _____ Jaundice? ____ Cyanosis?____ Congenital abnormalities or defects? _____ Explain: ____ Was your child subjected to any of the following? Silver Nitrate eye drops Vitamin K injection Hepatitis injection Incubation (how long)_____ Separation from the mother (how long) _____ Was the child alert & responsive within 12 hours of delivery? Pes No. Explain: Vaccination History Did you choose to vaccinate your child? Yes No If yes, please check all vaccinations received: DPT MMR Polio Chicken Pox Hepatitis Flu Other_____ Please describe your child's reaction to these vaccines: _____ Growth and Development Was the child breastfed?_____ How long?____ Any difficulties?____ At what age was formula introduced?____ Type:____ Cow's Milk?___ Solid Foods?_____ Has your child had antibiotics? Ves No If yes, which ones and why? At what age did the child: Respond to sound?_____ Follow an object?____ Hold up head?____ Sit unassisted?____ Crawl?___ Vocalize?___ Teethe?___ Walk?___ Has your child ever had any of the following? Irritability Seizures/convulsions Headaches Constipation Colic Hyperactivity Heart trouble Dizziness Frequent Colds Rashes Joint problems Allergies Ear Problems Flu Food Intolerances Scoliosis Eye Problems Bloody Noses Bed wetting Anemia Digestive Problems Sleeping disorders Asthma Hypertension **Breathing Problems** Poor Posture Meningitis Broken bones

Fatigue

Diarrhea

Muscular problems

Learning Disorders

According to the National Safety Council, approximately 50% of all children fall head first from a high place during their first year of life (changing table, bed, high chair, etc.) Was this the case with your child? Yes No
Has your child ever Fallen from heights over 2 feet? Yes No Been hospitalized? Yes No Been in a motor vehicle accident? Yes No Suffered a brain injury? Yes No Suffered a brain injury? Yes No Suffered any trauma not listed above? Is your child accident-prone? Yes No Any pets in the home? Yes No Smokers in the home? Yes No
Physical Activity and Childhood Nutrition Approximate # of hours of physical activity/ play time each week: # of hours of TV/computer each week: Does your child carry a backpack? Approximate weight of backpack: Does your child consume: Caffeine Soda Sugar Artificial sweeteners Fast Food Processed Food If applicable, has your child experienced menstruation? Yes No Age at onset? Medical Information Name of Pediatrician: Address: Date of last: Physical Exam: X-ray: Blood Test:
What changes in your child's health or behavior would you like to see? Who is on your health care team to help in cultivating these changes? We are excited to be a part of your child's health care team! We are here to serve you, and we encourage you to ask questions if anything is unclear. Your participation is crucial to your child's health and well-being.
Welcome to our chiropractic family! AUTHORIZATION FOR CARE OF A MINOR
I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTORS TO ADMINISTER A CHIROPRACTIC EXAMINATION AND CHIROPRACTIC CARE TO MY SON/DAUGHTER AS THEY DEEM NECESSARY. I DO CLEARLY UNDERSTAND AND AGREE THAT I AM RESPONSIBLE FOR PAYMENT OF ALL FEES CHARGED BY THIS OFFICE.
SIGNED:DATE:
WITNESS:DATE: