PERSONAL INFORMATION				
Date:				
Child's Name: First:		**Last:**		**Middle Initial:**
Parent(s) Name(s):				
Address: Street:			**City:**	
State:	**Zip:**		**Phone: ( )**	
Work Phone: ( )			**Cell: ( )**	
EMAIL:				
Child's Date of Birth: Month:	**Day:**	**Year:**	**Child's Sex (Circle One): M/F**	
Health Insurance:		**Primary Insurance Holder's DOB:**		
Referred By:				
Siblings: Name:	**Sex: (Circle One)**	**Birth Date**		
	Male/Female	**Month:**	**Day:**	**Year:**
	Male/Female	**Month:**	**Day:**	**Year:**
	Male/Female	**Month:**	**Day:**	**Year:**
Parent's Occupation(s):				
Diagnoses or explanation given to you about your child (Date of diagnoses: _____/_____/_____):				

PERSONAL INFORMATION (Continued)

Other problems to be addressed:

Describe your child to me, including his/her history. Please be as detailed as possible.

- **When did you first notice your child's problem?**
- **What did you first notice:**
- **Was the onset of your child's problem sudden or gradual?**
- **Was there any event or illness that you or others think brought on your child's symptoms?**

Please make notation of any other event, action, etc. that you think may have some bearing/relationship to your child's condition. Again, be as detailed as possible and do not hesitate to mention anything, no matter how small or insignificant, that you believe is related to your child's problem(s).

MEDICAL HISTORY		
PRIMARY DOCTOR(S)		
Name:	**Degree:MD/DO**	**Last Visit**
SPECIALISTS		
Name:	**Specialty:**	**Last Visit**
NUTRITIONIST		
Name:		**Last Visit**
NATUROPATH(S) and/ or HOMEOPATH(S)		
Name:		**Last Visit**
THERAPIST(S)		
Name:	**Type:**	**Last Visit**
OTHER		
Name:		**Last Visit**

PRENATAL HISTORY	
Maternal age at delivery: _____years	**# of Dental Amalgams (mom) _____**
Illnesses during pregnancy:	
Medication during pregnancy:	
Vaccines during pregnancy:	
Other complications during pregnancy:	
Complications during labor and delivery:	
Mode of delivery: C-section/vaginal? (Circle one) If C-section, explain why:	
If vaginal delivery, did you have forceps/vacuum?	
Medication(s) during labor and delivery?	
Full term/premature? (Circle one)	**How many weeks? _____weeks**
Complications after delivery?	
Medications given to child during hospital stay?	

_____

DIETARY/NUTRITONAL HISTORY

Breast fed? Yes/No (Circle one) If yes, for how long: _____

Bottle fed? Brand of formula? _____Begun at what age? _____ For how long? _____

Foods? Begun at what age?_____ First foods? _____

_____

Whole milk? Yes/No (Circle one) If yes, begun at what age? _____

Known allergies to food? (Please list):

_____

Suspected sensitivities to foods? (Please list):

_____

_____

Food cravings? (Please list):

_____

Foods my child eats: (Place X in appropriate column)

Food	Daily	3-5 times/ week	1-3 times/ week	Never or almost never	Used to eat a lot but no longer does
Cookies:					
Candy:					
Sweet foods:					
Caffeine (soda, tea, etc.):					
Chocolate:					
Milk: Whole:					
2 %:					
1 %:					
Skim:					
Cheese:					
Ice Cream:					
Salty Foods:					
Meat:					
Pasta:					
Bread:White/Wheat					
Other:					

Check (X) the most appropriate description below of your child's diet: **_____Mostly baby foods** **_____Mostly carbohydrates (bread, pasta, etc.)** **_____Mostly dairy (milk, cheese, etc.)** **_____Mostly vegetarian (vegetables, fruits, grains, etc.)** **_____Other, describe:**					
Please describe your child's stool pattern (Examples: daily, foul, large, mushy, etc.):					
Please list the foods and beverages normally consumed by your child for three typical days:					
DAY 1					
Breakfast:					
Morning snack(s):					
Lunch:					
Afternoon snack(s):					
Dinner:					
Other:					
DAY 2					
Breakfast:					
Morning snack(s):					
Lunch:					
Afternoon snack(s):					
Dinner:					
Other:					
DAY 3					
Breakfast:					
Morning snack(s):					
Lunch:					
Afternoon snack(s):					
Dinner:					
Other:					

FAMILY HISTORY

List any allergies, major illnesses, genetic diseases or problems for each of the following family members of your child:

Mother:

Father:

Siblings:

Maternal Grandparents:

Paternal Grandparents:

Others:

ENVIRONMENTAL HISTORY

Do you, your child, or any family members practice any relaxation management techniques? Please describe:

CIRCLE THE APPROPRIATE ANSWERS TO THE FOLLOWING QUESTIONS:

Location of home: City/Suburban/Wooded/Farm Other (describe):

Water: City/Well Purification system: Yes/No If yes, please describe:

Type of heat: Electric/Gas/Oil/Other If other, please describe:

Do you live near: Power lines/Woods/Industrial areas/Water?

If you live near water, list type: Swamp/River/Ocean/Other If other, please describe:

MEDICAL HISTORY (Continued)

Please send us all <u>recent</u> test results with this form (if applicable.)

Please list only tests that have been done and provide date and results

Evaluation/Test	Date	Results (normal, abnormal or unsure)

MEDICAL HISTORY (Continued)
Major surgeries - Please describe and give dates:
SURGERY
Major injuries - Please describe and give dates:
INJURY
MEDICATIONS
Please list any current /past medications being taken.
SUPPLEMENTS
Please list any current/past supplements being taken.
THERAPIES AND DIETS
Please list any current/past Therapies/Diets

VACCINATIONS

Please indicate date and any reactions for those immunizations that your child has received. If exact date isn't known, please approximate. "Bowel" refers to any bowel symptom such as diarrhea. "Swelling" refers to the site of the injection

Diptheria/Pertussis/Tetanus	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
DPT 1								
DPT 2								
DPT 3								
DPT 4								
DPT 5								
Adult Diptheris/Tetanus								
Pediatric Diptheris/Tetanus								
H Influenza Type B	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
Hib 1								
Hib 2								
Hib 3								
Hib 4								
Polio (circle Oral or Injection)	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
OPV 1 / Injection 1								
OPV 2 / Injection 2								
OPV 3 / Injection 3								
OPV 4 / Injection 4								
OPV 5 / Injection 5								
Measles/Mumps/Rubella	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
MMR 1								
MMR 2								
Hepatitis b Vaccine	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
HBV 1								
HBV 2								
HBV 3								
Prevnar (pnemococcal)								
Miscellaneous	**Date**	**Bowel**	**Swelling**	**Crying**	**Seizure**	**Irritable**	**Fever**	**Other**
Varivax (Chicken pox)								
Tine Test								
Flu Vaccine								
Other								

MUSCULOSKELETAL HISTORY

CHILD'S CURRENT PROBLEM:
If your child is experiencing ***Pain/Discomfort please identify where and for how long:***

1. **When did the** Problem first begin? Date ____/____/_____ _____Unknown ____Gradual ____Sudden
2. **Ever had** this problem **before**? No_____Yes_____

   If yes when? _____
3. Any **bowel or bladder** problems since this problem began?:

   If yes,(*Describe)*:_____
4. Have you seen any **other doctors** for this problem? No Yes

   If yes who? _____
5. How long ago? _____Days _____ Weeks _____ Months _____Years
6. What were the results of past treatment?
   _____
7. How is this problem **NOW:** ☐ Rapidly Improving ☐ Improving Slowly

   ☐ About Same ☐ Gradually Worsening ☐ On & Off
8. Has your child ever sustained an injury playing organized sports? _____ If yes; please explain_____
   _____
9. Has your child ever sustained an injury in an auto accident? _____

   if yes, please explain _____

HAS YOUR CHILD EVER SUFFERED FROM: *mark a* **Y for** *YES OR* ***N*** *NO*

□ Headaches	□ Orthopedic Problems	□ Digestive Disorders	□ Behavioral Problems
□ Dizziness	□ Neck Problems	□ Poor Appetite	□ ADD/ADHD
□ Fainting	□ Arm Problems	□ Stomach Aches	□ Ruptures/Hernia
□ Seizures	□ Leg Problems	□ Reflux	□ Muscle Pain
□ Heart Trouble	□ Joint Problems	□ Constipation	□ Growing Pains
□ Earaches	□ Backaches	□ Diarrhea	□ Allergies
□ Sinus Trouble	□ Poor Posture	□ Hypertension	□ Asthma
□ Scoliosis	□ Anemia	□ Colds/Flu	□ Walking Trouble
□ Bed Wetting	□ Colic	□ Broken Bones	□ Sleeping Problems

□ Fall in baby walker □ Fall from bed or couch □ Fall from crib □ Fall off swing □ Fall off bicycle
□ Fall from high chair □ Fall off slide □ Fall down stairs □ Fall off changing table
□ Fall off monkey bars □ Fall off skateboard/skates □ Other: _____

Please list any symptoms that you would like me to know about your child:

Please list any other history, pertinent thoughts or questions that you want addressed:

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 Dr. Jill's Chiropractic Care Center 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