Child Form: Age 2 and older

Date: ________________________

Child's Name ____ Date of Birth ______________________

Mother's Name ________________________________ Father's Name ________________________________

Address ____ Zip Code _________________________

Telephone (Home) _______________________________ Telephone (Work) _______________________________

Telephone (Mobile) _______________________________ E-Mail Address __________________________________

Can we text your appointment reminders? ☐ Yes ☐ No *(Please be sure you have provided a cell phone number.)*

How did you hear about Chiropractic/ this clinic? ____

Present Complaint ____

Have you consulted anyone else? ____

Is your child on any medication? ☐ Yes ☐ No

Has your child had any ☐ medical treatment/ ☐ scans / ☐ x-rays / ☐ surgery?

Was your child born with any congenital disorder? ____

Has your child had any vaccinations? ☐ Yes ☐ No Any reactions to vaccinations? ____________________

Has your child had any childhood illnesses? ____

Any known allergies? ____

Does your child have a good diet? ____

Which sports activities does your child do? ____

Regular bowel movements? __________________________ Does your child sleep well? ☐ Yes ☐ No

Physical development (i.e. weight gain, height gain, etc.) ____

Has your child had any significant falls/ accidents? ____

Has your child broken/fractured any bones? ____

Has your child had any antibiotics? ____

Has your child had any other prescription medication? ____

Does your child have any vitamin or mineral supplements? _______________________________________

How would you describe your child's emotional/mental health? ____________________________________

How would you describe your child's activity level? ____

Family history of medical problems? ____

Names & ages of siblings ____

____

FAMILY CHIROPRACTIC CENTER, LTD.

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OTHER PROBLEMS: Is or has your child ever experienced.

- ☐ Asthma
- ☐ Attention issues
- ☐ Back pain
- ☐ Balance or coordination issues
- ☐ Bedwetting
- ☐ Behavioral Problems
- ☐ Chronic fatigue
- ☐ Clicky hip
- ☐ Concentration issues
- ☐ Concussions issues
- ☐ Constipation
- ☐ Convulsions
- ☐ Diagnosed with ADHD
- ☐ Diagnosed with Autistic Spectrum Disorder
- ☐ Diarrhea
- ☐ Food Dislikes/Issues with foods
- ☐ Food intolerances
- ☐ Growing Pains
- ☐ Headaches
- ☐ Hyperactivity
- ☐ Joint problems
- ☐ Learning difficulties
- ☐ Neck pain
- ☐ Night Terrors
- ☐ Recurrent Colds/Earaches
- ☐ Scoliosis
- ☐ Sinus problems
- ☐ Tonsillitis

Any other information you think might be relevant? ____

____

PRENATAL / BIRTH

Any maternal illness or medical treatment during pregnancy? ____________________________________

____

Did your child follow his/her milestones?

7-9 months — sitting unaided? ☐ Yes ☐ No

9-12 months — standing unsupported? ☐ Yes ☐ No

Did your child bum-shuffle? ☐ Yes ☐ No

11 months — crawling? ☐ Yes ☐ No

14 months — walks unaided? ☐ Yes ☐ No

2 years — speech? ☐ Yes ☐ No

3 years — self-dressing? ☐ Yes ☐ No

CHILD CONSENT

I hereby authorize and consent for my child ______________________________ to be evaluated and treated by Dr. Bridget Horan, using chiropractic methods. The clinical procedures performed are gentle and usually beneficial. In rare cases underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor will not provide specific healthcare if she is aware that such care may be contraindicated. It is the responsibility of the patient's parent/guardian to inform the doctor of any and all health conditions by sharing a detailed health history, in its entirety.

Parent / Guardian ____
(signature)

Signed ____________________________ **Date** ____________________
(Print Name)