



Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____ S.S. #: _____

Address: _____

City: _____ State: _____ Zip _____

Home Phone: _____ Work Phone: _____

Birth Date: _____ Sex: _____ Weight: _____ Height: _____

Name of Parents/Guardians: _____

Referred By: _____

Purpose For Contacting us? _____

Other Doctors seen for this condition ___N___Y

Doctor's Name: _____

Prior Treatments: _____

Other health problems? _____

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

- | | | | | |
|--------------------|--------------|------------|------------------|-----------|
| Ear infections | Scoliosis | Seizures | Chronic Colds | Headaches |
| Growing Pains | Colic | Asthma | Bed Wetting | Allergies |
| Digestive Problems | Back Pains | Back Pains | Recurring Fevers | ADHD |
| Temper Tantrums | Car Accident | | | |
- Other _____

Family History _____

Previous Chiropractor _____

Date of last visit: _____ Reason: _____

Name of Pediatrician: _____

Date of last visit: _____ Reason: _____

Are you satisfied with the care your child has received there? ___N___Y

Number of doses of antibiotics your child has taken: During the past six months: _____

Total during his/her lifetime: _____

Number of doses of other prescription medications your child has taken: During the past six months: _____, Total during his/her lifetime: _____

List medications: _____

Vaccination History: _____

Prenatal History

Name of Obstetrician/Midwife: _____

Complications during pregnancy: ___N ___Y

If any complications please list: _____

Ultrasounds during pregnancy: ___N ___Y Number _____

Medications during pregnancy/delivery: ___N ___Y

Please list all medications during pregnancy/delivery: _____

Cigarette/alcohol use during pregnancy: ___N ___Y

Location of birth: ___ Hospital ___ Birthing Center ___ Home Birth

Intervention: ___ Forceps ___ Vacuum Extraction ___ Ceasarian Section

Emergency or Planned _____

Complications during delivery: ___N ___Y List: _____

Genetic disorders or disabilities: ___ N ___ Y List: _____

Birth weight: _____ Birth length: _____ APGAR Scores: _____, _____

Feeding History

Breast Fed: ___N ___Y How long _____

Formula Fed: ___N ___Y How long: _____ Type: _____

Introduced to solids at: _____ months, cows' milk at _____ months

Food/juice allergies or intolerance: ___N ___Y

List food or juice allergies: _____

Development History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to Sound _____ Cross Crawl

_____ Respond to visual stimuli _____ Stand Alone

_____ Hold Head Up _____ Walk Alone

_____ Sit Up

According to the national safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.). Was this the case with your child? ____ N ____ Y

Is/has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ____ N ____ Y

Has your child ever been involved in a car accident? ____ N ____ Y List: _____

Has your child been seen on an emergency basis? ____ N ____ Y List: _____

Any other traumas not described above: ____ N ____ Y List: _____

Prior surgery: ____ N ____ Y List: _____

Childhood Diseases:

Chicken Pox ____ N ____ Y Age _____ Mumps ____ N ____ Y Age _____

Rubella ____ N ____ Y Age _____ Whooping Cough ____ N ____ Y Age _____

Rubeola ____ N ____ Y Age _____

Other ____ N ____ Y Age _____ Describe _____

WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATIONS FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my son/daughter, as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company _____

Policy #: _____

Parent/Guardian Signature: _____

Witnessed: _____

Date: _____

PATIENT NAME _____ ACCOUNT # _____ DATE _____

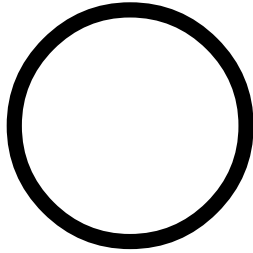
DEVELOPMENTAL ASSESSMENT (check all that apply)

- | | | |
|--------------|---|--|
| 2 months | <input type="checkbox"/> Keeps hands fisted | <input type="checkbox"/> Smiles responsively |
| | <input type="checkbox"/> Lifts head for several seconds | <input type="checkbox"/> Begins to vocalize |
| 3 months | <input type="checkbox"/> Lifts head above body plane | <input type="checkbox"/> Watches own hands |
| | <input type="checkbox"/> Turns head toward object | <input type="checkbox"/> Smiles and vocalized in response |
| 4 months | <input type="checkbox"/> Sits with head steady | <input type="checkbox"/> Turns head toward sounds |
| | <input type="checkbox"/> Reaches for object | <input type="checkbox"/> Smiles spontaneously |
| 5-6 months | <input type="checkbox"/> Lifts head while supine | <input type="checkbox"/> Babbles |
| | <input type="checkbox"/> Exhibits no head lag | <input type="checkbox"/> Localizes direction of sound |
| 7-8 months | <input type="checkbox"/> Sits alone tripod fashion | <input type="checkbox"/> Mouths all objects |
| | <input type="checkbox"/> Feeds self cracker | <input type="checkbox"/> Non specific "dada", "baba" |
| 9-10 months | <input type="checkbox"/> Sits well without support | <input type="checkbox"/> Waves "bye-bye" |
| | <input type="checkbox"/> Stands holding on | <input type="checkbox"/> Drinks from a cup with assistance |
| 11-12 months | <input type="checkbox"/> Walks with assistance | <input type="checkbox"/> Uses 2-4 words with meaning |
| | <input type="checkbox"/> Crawls well | <input type="checkbox"/> Assists with dressing |
| 13-15 months | <input type="checkbox"/> Walks by self; falls easily | <input type="checkbox"/> "Dada/" "Mama" specific |
| | <input type="checkbox"/> Cruises | <input type="checkbox"/> Points to things wanted |
| 18 months | <input type="checkbox"/> Climbs stairs with assistance | <input type="checkbox"/> Feeds self |
| | <input type="checkbox"/> Throws ball | <input type="checkbox"/> Uses many intelligible words |
| 24 months | <input type="checkbox"/> Kicks ball | <input type="checkbox"/> Handles spoon well |
| | <input type="checkbox"/> Runs; climbs stairs along | <input type="checkbox"/> Speaks 2-3 word sentences |
| 30 months | <input type="checkbox"/> Jumps | <input type="checkbox"/> Knows full name |
| | <input type="checkbox"/> Walks on tiptoes | <input type="checkbox"/> Recognizes three colors |
| 36 months | <input type="checkbox"/> Pedals tricycle | <input type="checkbox"/> Walks up stairs alternating feet |
| | <input type="checkbox"/> Stands on one foot | <input type="checkbox"/> Knows age and sex |
| 48 months | <input type="checkbox"/> Throws ball overhand | <input type="checkbox"/> Buttons large buttons |
| | <input type="checkbox"/> Climbs well | <input type="checkbox"/> Plays with several children |
| 60 months | <input type="checkbox"/> Skips | <input type="checkbox"/> Dresses and undresses |

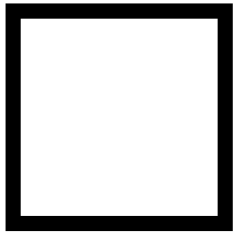
COGNITIVE DEVELOPMENT

Have the patient copy the following

Age 3



Age 4



Age 6

