CHILD HISTORY FORM

Date _____

Please complete this detailed history form and return it to the receptionist. Should you require any assistance, please let us know, as we would be happy to assist.

Name _____ Tel _____

Address _____ Zip _____

Date of Birth _____ Referred by _____

Health Ins Co _____ Name of Insured _____

DOB of Insured _____ S.S. # of Insured _____

Present MD & Address _____

Previous DC & Last Visit _____

Present Length _____ Present Weight _____

AUTHORIZATION FOR CARE OF A MINOR

Parent(s) Names _____ Bus Tel _____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature _____ _____ Witness Initials _____

CHIEF HEALTH CONCERNS _____

_____

REASON FOR CONTACTING US _____

LIST OTHER CARE UNDERGONE FOR THIS COMPLAINT including medications _____

_____

Date of Onset ____/____/____Onset was Sudden / Gradual / Associated with an event

Duration of problem (episode) _____ minutes / hours / days / months / years

Pattern of problem Constant / Intermittent / Occupational / Cyclical

Initiating factors _____

Aggravating factors _____

Relieving factors _____

Effects of problems on body function and daily activities _____

_____

Prior occurrence or episodes _____

OTHER HEALTH CONCERNS _____

HISTORY OF BIRTH

Hospital / birthing center: ❑ home ❑ medical ❑ midwife Duration of Gestation: _____weeks

Assisted With: ❑ No ❑ Yes. If yes: ❑ forceps, ❑ vacuum extraction, ❑ c-section, ❑ induced labour.

Medications delivered to mother at birth? ❑ No ❑ Yes. If yes what? _____Duration of birth: _____

Complications at birth: ❑ No ❑ Yes Explain_____ Was delivery normal? ❑ Yes ❑ No

APGAR at BIRTH_____ AFTER 5 MINUTES _____BIRTH WEIGHT _____BIRTH LENGTH_____

GROWTH AND DEVELOPMENT

Was the infant alert and responsive within twelve hours of delivery? ❑ Yes ❑ No Explain_____

At what age did the child: Respond to sound _____ Follow an object_____ Hold up head_____ Vocalize _____

Sit alone _____Teethe_____ Crawl _____ Walk _____Do sleeping patterns seems normal to you: ❑ Yes ❑ No. Any health problems (cancer, diabetes, heart disease, etc.) on the mother' side of the family_____ On the father's_____ With siblings _____ Since problems that chiropractors concern themselves with can be related to many types of stressors, the following information is also very important to us!

CHEMICAL STRESSORS:

Was this baby breast-fed? ❑ No ❑ Yes How long _____Formula introduced at age _____ Type of formula used _____Introduction of cow's milk at age _____Began solid foods at age_____ Type_____ Age & type of commercial baby food introduction_____ Food /Juice intolerance ❑ No ❑ Yes Type:_____

During pregnancy did the mother smoke? ❑ Yes ❑ No Did the mother drink alcohol? ❑ Yes ❑ No. Any illness of the mother during pregnancy? _____ Any supplements of mother during pregnancy:_____

Any drugs taken during pregnancy _____Any exposures to ultrasound: ❑ No ❑ Yes If so, how many and what was the medical reason? _____Any invasive procedures (amniocentesis, CVS): _____

Any pets at home? ❑ No ❑ Yes Any smokers in the home? ❑ No ❑ Yes (How much) _____Any vaccinations? Which ones and any reactions? _____Any antibiotics? ❑ No ❑ Yes Explain:_____

Total number of courses of antibiotics to date: _____

PSYCHOSOCIAL STRESSORS.

Any difficulties with lactation?: ❑ No ❑ Yes Any problems with bonding? ❑ No ❑ Yes Any behavioural problems? ❑ No ❑ Yes Onset: _____Any night terrors, sleepwalking, difficulty sleeping? ❑ No ❑ Yes Specify_____Age of child when began daycare? _____ Average number of hours of television/week? _____ Does your child seem normal for their age? ❑ Yes ❑ No

TRAUMATIC STRESSORS:

Any traumas during pregnancy (falls, accidents)_____Any evidence of birth trauma: bruises, odd shaped head, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, other_____

Any falls from couches beds, change tables _____Any traumas with bruising, cuts, stitches fractures_____

Any hospitalizations: ❑ No ❑ Yes Explain_____

Any surgeries or organs removed _____Sports played and age began _____

_____Number of hours per week played_____

Weight of school backpack_____Approx. hours spent at play per week_____

Thank you for completing this form. Please write any other questions you have below._____

_____

_____

FAMILY HEALTH JOURNAL

Patient Name: _____ Date: _____

Kindly review the following list of disabilities and indicate which are current or past health problems of a family member by checking the appropriate box.

Family Member	Father	Mother	Spouse	Brother(s)	Sister(s)	Child 1	Child 2	Child 3
Condition:								
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Asthma/Hay fever	☐	☐	☐	☐	☐	☐	☐	☐
Back problems	☐	☐	☐	☐	☐	☐	☐	☐
Bursitis	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Constipation	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Disc problem	☐	☐	☐	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐
Blood pressure High/Low	☐	☐	☐	☐	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐	☐	☐	☐
Lung disease	☐	☐	☐	☐	☐	☐	☐	☐
Lymphs disease	☐	☐	☐	☐	☐	☐	☐	☐
Migraine headaches	☐	☐	☐	☐	☐	☐	☐	☐
Nervousness	☐	☐	☐	☐	☐	☐	☐	☐
Neuritis	☐	☐	☐	☐	☐	☐	☐	☐
Neuralgia	☐	☐	☐	☐	☐	☐	☐	☐
Pinched nerve	☐	☐	☐	☐	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐	☐	☐	☐	☐
Sinus trouble	☐	☐	☐	☐	☐	☐	☐	☐
Stomach trouble	☐	☐	☐	☐	☐	☐	☐	☐

Other: _____

_____

_____

_____

NEW LIFE
Family Chiropractic Center PC
P.O. BOX 11988
MERRILLVILLE, IN 46411
219-769-5433
219-769-6072

Patient Name: _____

I hereby request and authorize the doctors of New Life Family Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatment to **MY MINOR CHILD:** _____, **THE AGE OF:** _____. This authorization is for diagnosis and treatment rendered at this office. It is intended to include radiographic examination at the doctors' discretion.

As of the date shown on this document, I have the legal right to select and authorize health care services for the minor child named above.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/ former spouse or other parent is no required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office. I understand that all services are ultimately my financial responsibility.

Date: _____ _____
Signature

_____ _____
Witness Printed Name

_____
Relationship to Patient