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This information is strictly confidential. Your answers will help us determine if chiropractic can help your child. If we do not sincerely believe your child's condition will respond satisfactorily, we will not accept your case. Please be as accurate as possible.

I understand and agree that all services rendered to my child are charged directly to me and that I am personally responsible for payment. I understand that all examinations and treatments are to be paid for as they are received unless definite financial arrangements are made in advance.

I hereby authorize Dr. Lydia Knutson or Dr. Theresa Hopkins to examine and treat my child's condition as she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed.

Parent or Guardian's signature _____ Date _____

PLEASE DO NOT WEAR PERFUMES, AFTERSHAVES OR OTHER SCENTS TO THIS OFFICE.
SOME PATIENTS ARE ALLERGIC.

PATIENT INFORMATION

Name _____ Today's Date _____
Address _____ Parent Name(s) _____
City, State, Zip _____ Parent Occupations(s) _____
Phone (home) _____
Social Security Number _____ Parent Employer(s) _____
Date of Birth _____ Age _____
Gender: F M Height: ____ ft ____ in Weight: _____ Parent Email _____
Medical Doctor _____ Parent Work Phone _____
Date of last check-up _____ Parent Cell Phone _____
Travel time to this office _____ Referred to our office by _____
Name/ Age of Sibling(s) _____
Other Household Members (include extended family, non-family and pets) _____

Name of person responsible for payment of professional services _____

CURRENT HEALTH REPORT

What are the primary health or developmental concerns with this child?

1. _____

2. _____

3. _____

BIRTH HISTORY

Term: Full / Premature / Late C-Section? _____ Did mother go into labor? _____ Length of Labor _____

Weight at Birth _____ Birth/fetal pregnancy complications _____

Feeding: Breast fed How long? _____ Formula Milk/Soy Solid foods at age _____

Baby's sleep pattern first year _____

Does child sleep well now? _____

As a baby did this child experience:

- | | | | |
|--|-----------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Colic | <input type="checkbox"/> Fever | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Birth Injury | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Birth Defects | | | |

DEVELOPMENTAL HISTORY

Physical Development

Age began: Rolling over _____ Sitting _____ Crawling _____ Walking _____

Any difficulties with:

- | | | |
|-----------------------------------|---|---|
| <input type="checkbox"/> Crawling | <input type="checkbox"/> Somersaults | <input type="checkbox"/> Throwing/Catching a Ball |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Climbing | <input type="checkbox"/> Activities on the Playground |
| <input type="checkbox"/> Running | <input type="checkbox"/> Riding a Bike | <input type="checkbox"/> Gross Motor Activities |
| <input type="checkbox"/> Hopping | <input type="checkbox"/> Swimming | <input type="checkbox"/> Fine Motor Activities |
| <input type="checkbox"/> Skipping | <input type="checkbox"/> Organizing/Remembering Sequential Activities or Thoughts | |

If any difficulties, please explain: _____

Sensory Integration Issues

Sensitivity to: Light Sound Smells Tactile Stimulation Picky Eater (texture/taste)

Language and Social Development

Age of First Words _____ Sentences _____ Is s/he reading yet? _____ Age began reading _____

How easily does s/he communicate needs and desires? _____

Is s/he cooperative? _____ Able to follow instructions? _____

Unusual skills or interests: _____

Desire and ability to communicate with:

Parents _____ Peers _____ Adults _____

Siblings _____ Older Children _____ Strangers _____

Describe his/her relationships with siblings: _____

Is s/he a Leader? _____ Follower? _____ Socially flexible? _____

Does s/he have many friends? _____ A few close friends? _____

Emotional traumas: _____

Extended family (or committed adult family friends) with whom the child has regular contact: _____

Notable developmental histories of biological siblings: _____

DIET AND LIFESTYLE

Please describe your child's typical daily diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Sweets _____

Food cravings: _____

Any known food, environmental or medication allergies/intolerances? Please list: _____

Does your child routinely eat processed foods (bologna, sausage, processed cheese, baked goods)? If so, what? _____

Artificial colors/sweeteners? _____ Has child ever tried a gluten free/dairy free diet? _____

How many hours per day does your child spend:

____ hours playing outdoors (weather permitting)

____ hours of unstructured time in imaginary play

____ hours of computer time

____ hours of unstructured time with friends

____ hours watching TV/video

Favorite activities _____

MEDICAL HISTORY

Injuries

Head injuries _____

Other major falls or injuries _____

Surgeries/Hospitalizations _____

Infections

Has this child had any of the following infections:

Bronchitis

Frequent Colds

Pneumonia

Tonsillitis

Chicken Pox

Measles

Rubella

number of times ____

Croup

Mumps

Scarlet Fever

Ear Infections

number of times ____

Immunizations

Chicken Pox

Hepatitis B

MMR

Smallpox

Diphtheria

Influenza

Mumps

Tetanus

DPT

Measles

Polio

Other _____

Any adverse reactions? Please describe: _____

Symptoms

Please circle: **Y** = current condition **N** = never had **P** = has had in the past

Y N P acne	Y N P bloody urine	Y N P flat feet
Y N P excema	Y N P hearing loss	Y N P joint pains
Y N P hives	Y N P heart murmur	Y N P nervousness
Y N P asthma	Y N P anemia	Y N P dizzy spells
Y N P high fevers	Y N P stomach aches	Y N P body/breath odor
Y N P chronic rash	Y N P constipation	Y N P motion/car sick
Y N P canker sores	Y N P diarrhea	Y N P nightmares
Y N P sore throat	Y N P gas	Y N P unusual fears
Y N P wheezing	Y N P no appetite	Y N P night sweats
Y N P bleeding gums	Y N P insatiable hunger	Y N P cries easily
Y N P nose bleeds	Y N P jaundice	Y N P inconsolable crying
Y N P burning urination	Y N P bruises easily	Y N P excessive fatigue
Y N P frequent urination		

Any other condition not previously mentioned _____

Any current medications (prescription and non-prescription): _____

IMAGING AND SPECIAL STUDIES

	When	Where	Results
Hearing Test	_____	_____	_____
Vision Test	_____	_____	_____
Speech/Language	_____	_____	_____
Behavioral Assessment	_____	_____	_____
X-ray	_____	_____	_____
Other _____	_____	_____	_____

FAMILY HISTORY

Has any immediate family member had any of the following:

- | | | | |
|------------------------------------|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Illness |

Health of biological siblings _____

Previous pregnancies by birth mother, miscarriages or complications _____

Mother's health during pregnancy:

- | | | | |
|--|-------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Alcohol consumption | <input type="checkbox"/> Drug use | <input type="checkbox"/> Nausea | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Illness | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Physical/emotional trauma | Mother's age at child's birth _____ | | |