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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 young person?

- 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 _____
Sleep pattern during first year _____
Does s/he sleep well now? _____
As a baby did s/he experience:
 Allergies Colic Fever Rashes
 Birth Injury Diarrhea Jaundice Seizures
 Birth Defects

DEVELOPMENTAL HISTORY

Physical Development

Age began: Rolling over _____ Sitting _____ Crawling _____ Walking _____
Any difficulties with:
 Crawling Somersaults Throwing/Catching a Ball
 Walking Climbing Activities on the Playground
 Running Riding a Bike Gross Motor Activities
 Hopping Swimming Fine Motor Activities
 Skipping Organizing/Remembering Sequential Activities or Thoughts
If any difficulties, please explain: _____

School History, Language and Social Development

Current Grade Level _____ Current Grade Level for Reading _____ Current Grade Level for Writing _____
Areas of Academic Ease _____
Areas of Academic Difficulty _____
Favorite Subjects _____
Unusual skills or interests: _____
Desire, ease 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? _____
How easily does s/he listen and cooperate with others? _____ Follow Instructions? _____
Emotional traumas: _____
Extended family (or committed adult family friends) with whom this young person has regular contact: _____

Notable developmental histories of biological siblings: _____

Sensory Integration Issues

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

DIET AND LIFESTYLE

Please describe his/her typical daily diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Sweets _____

Food cravings: _____

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

Does s/he routinely eat processed foods (bologna, sausage, processed cheese, baked goods)? If so, what? _____

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

How many hours per day does s/he 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 s/he 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

Has s/he had standard childhood vaccinations? yes no Any adverse reactions? Please describe: _____

When his/her condition first appeared, about how long was it after their most recent vaccination, and which vaccination was that? _____

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 _____ | |