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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"/> Rolling Over | <input type="checkbox"/> Running     | <input type="checkbox"/> Activities on a Play Structure |
| <input type="checkbox"/> Crawling     | <input type="checkbox"/> Somersaults | <input type="checkbox"/> Gross Motor Activities         |
| <input type="checkbox"/> Walking      | <input type="checkbox"/> Climbing    | <input type="checkbox"/> Fine Motor Activities          |

If any difficulties, please explain: \_\_\_\_\_

Unusual Skills or Interests \_\_\_\_\_

### Sensory Integration Issues

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

### Language Development

Age of First Words \_\_\_\_\_ Sentences \_\_\_\_\_

### Daily Activities

How many hours does your child spend playing out of doors each day? \_\_\_\_\_

How many hours does your child spend on computer, TV or video time? \_\_\_\_\_

Favorite Activities: \_\_\_\_\_

### Social Development

Desire and ability to communicate with:

Parents \_\_\_\_\_ Peers \_\_\_\_\_ Adults \_\_\_\_\_

Siblings \_\_\_\_\_ Older Children \_\_\_\_\_ Strangers \_\_\_\_\_

Describe his/her relationships with siblings: \_\_\_\_\_

Emotional traumas: \_\_\_\_\_

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

Notable developmental histories of biological siblings: \_\_\_\_\_

## DIET

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? \_\_\_\_\_

## MEDICAL HISTORY

### Injuries

Head injuries \_\_\_\_\_

Other major falls or injuries \_\_\_\_\_

Other traumatic events ( \_\_\_\_\_

Surgeries/Hospitalizations \_\_\_\_\_

### Infections

Has this child had any of the following infections:

- |                                      |   |  |   |
|--------------------------------------|---|--|---|
| <input type="checkbox"/> Bronchitis  | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Pneumonia     | <input type="checkbox"/> Tonsillitis    |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles        | <input type="checkbox"/> Rubella       | number of times ____                    |
| <input type="checkbox"/> Croup       | <input type="checkbox"/> Mumps          | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Ear Infections |

Approximate number of antibiotic prescriptions in child's lifetime \_\_\_\_\_ number of times \_\_\_\_

### Immunizations

Has your child had standard childhood vaccinations?  yes  no Any adverse reactions? Please describe: \_\_\_\_\_

\_\_\_\_\_

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

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 _____ |   |                                      |