Complete Chiropractic

5930 Hamilton Blvd.
Unit 8
Allentown, P A 18106
(610)841-2204

Name: _____Age: _____ Birth Date: _____

Address: _____City: _____State _____Zip: _____

Mother's Name: _____ Father's Name: _____

Parents' email address: _____

Would you like to receive our monthly informative health e-newsletter? (you may opt out at anytime) Y N
May we contact you with office happenings via email? (approx. 4-6 a yr.) Y N

Phone #: _____SSN: _____Birth Date: _____□ Male □ Female

Pediatrician/Family Doctor: _____

Whom may we thank for referring you? _____

# Health Profile

As a family chiropractic office we focus on your child's ability to be healthy. Our goals are first to address the issues that brought you to this office, and second, to offer you and your child - the opportunity of improved health potential and wellness services.

What brings the patient in today? _____
_____
_____

If your child has no symptoms or complaints, and is here for wellness services, please check □; others need to briefly describe the chief area of complaint, including the effect it has on the child.

If he/she is experiencing pain, is it □ Sharp □ Dull □ Comes and Goes □ Travels □ Constant Since the problem started, is it: □ About the same □ Getting better □ Getting worse?

What makes it worse? _____

It interferes with: □ School □ Sleep □ Walking □ Sitting □ Hobbies □ Other: _____

Other doctors seen for this problem:

Chiropractor: _____ Date(s): _____

Medical doctor: _____ Date(s): _____

Other: _____ Date(s): _____

List medications the child is taking or surgeries the child has had:

_____

_____

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to you child's health potential.

**Pregnancy:**

Were there any complications to the pregnancy? _____

Was Mom on any medications, prescription or over-the-counter? □Yes □ No

If yes, explain:_____

Did Mom or Dad smoke during pregnancy? □ Yes □ No Who? _____

Was the baby ever in the Breech position? □ Yes □ No

How many ultrasounds were performed? _____

**Birth and Delivery**

Where was the baby born? □ Home □ Hospital □ Birthing Center □ Other: _____

Was the delivery: □ Vaginal □ C-section Were any devices used? □ Forceps □ Vacuum

How long was the labor? How long was the delivery? _____

Was oxytocin/pitocin used? Yes No Was an epidural administered? □ Yes □ No

**Infancy:**

Was the infant vaccinated? □Yes □ No

Was there any prolonged use of medicines or an inhaler? □Yes □ No If yes, which: _____

Did the infant suffer any traumas such as serious falls or car accidents? □ Yes □ No

Has the infant been under regular chiropractic care? □Yes □ No

**Childhood years:**

Did the child have any childhood illnesses? □ Yes □ No Explain: _____

Does the child play youth sports? □ Yes □ No Which sport(s)? _____

Has the child had any surgery? □ Yes □ No Explain: _____

Has the Child fallen from a height over 3ft? □ Yes □ No Explain: _____

Was the child involved in any car accidents? □ Yes □ No When? _____

Has there been any prolonged use of medication? □ Yes □No Explain: _____

Has the child suffered emotional traumas? □ Yes □ No Explain: _____

Please give us any other health information you feel would be helpful: _____

_____

I have read and completed all answers to the above questions to the best of my knowledge. I am aware that answering yes to any of the above questions may require my child to undergo further testing prior to starting any appropriate care. I hereby give my full consent to undergo a care program designed for my child if determined to be clinically medically necessary by my doctor. I will notify them of any changes in my child's health status during the duration of the program. It is also my duty to daily inform the doctor or assistant of any possible complication prior to the initiation of my child's daily treatment.

Your signature _____ Date _____

Physician signature _____ Date _____