McANDREWS FAMILY CHIROPRACTIC

Creating healthier, happier, humans

PATIENT INFORMATION

Child's Name: _____ **DOB:** _____ **Parent's Name:** _____

Street Address: _____ **City/State/Zip Code:** _____

Phone Number: _____ **Email:** _____

Who is your child's PCP? _____ **How did you hear about us?** _____

Is your child receiving care from any other health professional? ◯ Yes ◯ No

If yes, please explain? _____

Please list any drugs/medications/vitamins/herbs that your child is taking: _____

Who can we thank for referring your child to our office?* _____

CURRENT HEALTH CONDITIONS

What health condition(s) bring your child to be evaluated by a chiropractor? _____

When did the condition first begin? How did the problem start? _____

_____

Has your child received care for this condition before? ◯ Yes ◯ No

If yes, please explain? _____

Is this condition: ◯ Getting Worse ◯ Improving ◯ Intermittent ◯ Constant ◯ Unsure

What makes the problem better? _____

What makes the problem worse? _____

During which activities is it most noticeable? _____

HEALTH GOALS FOR YOUR CHILD

What is your top health goal for your child? _____

Have you ever visited chiropractor? ◯ Yes ◯ No **If yes, what is their name?** _____

What would you like to gain from chiropractic care? ◯ Resolve existing condition ◯ Overall wellness ◯ Both

PRENATAL HISTORY

Is your child adopted? ◯ Yes ◯ No

Did you have any complications? ◯ Yes ◯ No If yes, when? _____

Did you smoke? ◯ Yes ◯ No **Did you consume alcohol?** ◯ Yes ◯ No

Did you take medication? ◯ Yes ◯ No **Did you exercise?** ◯ Yes ◯ No

Please explain any notable episodes of mental/physical stress during your pregnancy:

_____

Please explain any other concerns or notable remarks about your child's conception:

_____

BIRTH HISTORY

Did you have an ultrasound during this pregnancy? ◯ Yes ◯ No **What was the frequency?** _____

Place of birth: ◯ Home ◯ Birthing Center ◯ Hospital ◯ Other _____

Provider: ◯ Midwife ◯ OB-Gyn ◯ Other

Type of Birth: ◯ Vaginal ◯ Emergency C-Section ◯ Scheduled C-Section

Were medications used? ◯ Yes ◯ No

Was labor induced? ◯ Yes ◯ No **If yes, why?** _____

What position did you deliver in? ◯ Squatting ◯ On Back ◯ Other _____

Please check any applicable interventions or complications: ◯ Breech ◯ Induction ◯ Pain meds ◯ Epidural ◯ Episiotomy ◯ Doctor Assisted ◯ Twisting/Pulling ◯ Vacuum Extraction ◯ Forceps

Please describe any other concerns or notable remarks about your child's labor and/delivery:

_____

Childs Birth Weight: _____ **Childs Birth Height:** _____ **APGAR Score:** _____

GROWTH & DEVELOPMENT HISTORY

Is/was your child breastfed? ◯ Yes ◯ No **Do/did you have difficulty with breastfeeding?** ◯ Yes ◯ No

Do/did they ever use formula? ◯ Yes ◯ No

Did/does your child suffer from colic, reflux, or constipation as an infant? ◯ Yes ◯ No

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ◯ Yes ◯ No

Please list any food intolerances/allergies and when they began: _____

Please list your child's hospitalization and surgical history, including the year: _____

_____

Please list any major injuries, accidents, falls, and/or fractures your child has sustained in his/her lifetime, including the year: _____

Have you chosen to vaccinate your child? ◯ Yes, on schedule ◯ Yes, on a delayed/selective schedule ◯ No

If yes, please list any vaccine reactions: _____

Night terrors or difficulty sleeping? ◯ Yes ◯ No If yes, please explain: _____

Behavioral, social, emotional issues? ◯ Yes ◯ No If yes, please explain: _____

How many hours per day does your child typically spend watching TV, computer, tablet or phone? _____

BABY/TODDLER (0-4 YEARS OF AGE)

Have any of the following occurred? ◯ Fall from changing table ◯ Fall out of crib ◯ Tumble down stairs
◯ Fall off of playground equipment ◯ Involvement in MVA ◯ Play in Johnny Jumper ◯ Reaction to vaccines
◯ Frequent crying spells ◯ Sleeping problems ◯ Colic ◯ Repeated infections/colds ◯ Frequent fevers
◯ Frequent diarrhea ◯ Frequent ear infections ◯ Constipation ◯ Tonsillitis

CHILD (5-12 YEARS OF AGE)

Have any of the following occurred? ◯ Fall from a tree ◯ Fall off of a bicycle ◯ Sports accident
◯ Car accident ◯ Stomach pains ◯ Scoliosis ◯ Bed wetting ◯ Fall on playground ◯ Hyperactivity/Autism
◯ Learning difficulties ◯ Asthma ◯ Allergies ◯ Leg/knee pain ◯ Other _____

Which of the above bothers your child the most? _____

Is it getting worse? ◯ Yes ◯ No Is the pain: ◯ Constant ◯ Intermittent ◯ Cyclic

Affect on activity? ◯ Yes ◯ No

Does your child participate in any of the following? ◯ Soccer ◯ Football ◯ Gymnastics ◯ Karate
◯ Hockey ◯ Lacrosse ◯ Basketball ◯ Dance ◯ Wrestling ◯ Baseball/Softball ◯ Volleyball
◯ Tennis ◯ Swimming ◯ Rugby ◯ Other _____

How would you rate your child's diet? ◯ Well balanced ◯ Average ◯ High sugar/processed foods

Does your child consume artificial sweeteners? ◯ Yes ◯ No **Fluoridated water?** ◯ Yes ◯ No

Number of hours your child sleeps: _____ hours per day **Sleep quality:** ◯ Good ◯ Fair ◯ Poor

ACKNOWLEDGEMENT & CONSENT

I do hereby authorize, request, and direct Dr. McAndrews and whomever she may designate as assistant to perform in judgement any examination and chiropractic diagnosis or treatment which is deemed necessary.

Parent Signature: _____ **Date:** _____