Sleigh Family Chiropractic

PATIENT INFORMATION

Child's Name: _____ Child's Nickname: _____

Birth Date: _____/_____/_____ Age: _____ Sex: ❑M ❑F

Present Health Challenge: _____

How do you feel your child's present health challenge affects their overall health and ability to have an optimal quality of life? _____

_____

Do you feel your child's environment is related to their present health challenge? ❑YES ❑NO

If so, how? _____

Do you feel your child's diet is related to their present health challenge? ❑YES ❑NO

If so, how? _____

Please list any other concerns regarding your child's overall health: _____

_____

Child's Address (if different from your own): _____

Contact Email Address: _____

FAMILY INFORMATION

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

Address: _____ Address: _____

_____ _____

Phone Number: ( )_____ Phone Number: ( )_____

❑ I would like to opt out of receiving SMS messages and appointment reminders. I understand that Sleigh Family Chiropractic will no longer be able to communicate with me via SMS.

Parents' Marital Status: ❑Married ❑Single ❑Divorced ❑Widowed ❑Other

Names and ages of other children in the family: _____

Primary language(s) used at home: _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Phone Number: ( ) _____

REFERRAL (if applicable)

Referred By: _____

PAYMENT INFORMATION

If you have insurance that may cover chiropractic services, please provide your current insurance card so that we may make a copy. Please enter the following information **in relation to the insurance holder**.

Insured's Name: _____ Insured's Birth Date: _____/_____/_____

Insurance Company: _____ Member ID: _____

❑ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

PREGNANCY HISTORY

What was the term of the pregnancy? _____ weeks

During pregnancy, did any of the following occur?

- ❑ Falls
- ❑ Motor Vehicle Accident
- ❑ Near-Miss Motor Vehicle Accident
- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Anemia
- ❑ Morning Sickness
- ❑ Indigestion
- ❑ Seizures
- ❑ Swollen Ankles
- ❑ Thyroid Problems
- ❑ Heart Problems
- ❑ Back Pain
- ❑ Abnormal Bleeding
- ❑ Hospitalization
- ❑ Other Illnesses: _____

During pregnancy, were any of the following used?

- ❑ Tobacco
- ❑ Non-Prescribed Drugs
- ❑ Alcohol
- ❑ Prescription Medications: _____
- ❑ Over-the-Counter Medications: _____

BIRTH HISTORY

LABOR AND DELIVERY

How long was labor from the first regular contractions to the birth? _____ hours

How long was the second stage (pushing phase) of labor? _____ hours

Birth Details:

- ❑ Hospital Birth
- ❑ Midwife Assisted
- ❑ Planned C-Section
- ❑ Induced
- ❑ Vacuum Extraction
- ❑ Fetal Distress
- ❑ Head Presentation
- ❑ Breech Presentation
- ❑ Home Birth
- ❑ Vaginal Delivery
- ❑ Emergency C-Section
- ❑ Forceps Delivery
- ❑ Anesthesia Administered
- ❑ Meconium Staining
- ❑ Face Presentation

CONDITION AFTER BIRTH (IF KNOWN)

Color: ❑Pink all over ❑Blue face ❑Blue hands/feet

Was intensive care required? ❑YES ❑NO **If yes, days in NICU: _____** days

Medication given at birth: _____

Vaccines administered: _____

Birth Weight: _____ lbs **_____** oz **Birth Length: _____** in / cm **Baby Home on Day _____**

INFANT HISTORY

NUTRTITION

Is your child currently being breast fed? ❑YES ❑NO

If yes, how much cow's milk does the mother consume each day? _____

If no, for how long was your child breast fed? _____

Is your child currently formula fed? ❑YES ❑NO **If yes, which formula? _____**

Is your child eating solid food? ❑YES ❑NO

Which foods are in your child's diet? _____

_____

Does your child have any feeding difficulties? ❑YES ❑NO

If yes, explain: _____

Does your child have any digestive issues? ❑YES ❑NO

If yes, explain: _____

Does your child have any food allergies? ❑YES ❑NO

If yes, explain: _____

Does your child have any persistent or intermittent skin rashes? ❑YES ❑NO

If yes, explain: _____

Is your child taking any vitamin supplements? ❑YES ❑NO

If yes, explain: _____

TRAUMA

Has your child had any recent falls, accidents, or physical trauma? ❑YES ❑NO

If yes, explain: _____

Has your child ever had a broken bone, fracture, or dislocation? ❑YES ❑NO

If yes, explain: _____

Does your child ever bang their head repeatedly against a wall, bed, or other object? ❑YES ❑NO

If yes, explain: _____

GROWTH AND DEVELOPMENT

At what age was your child able to sit up unsupported? _____ months

At what age did your child begin to crawl? _____ months

At what age did your child begin to walk? _____ months

Does your child often trip and fall? ❑YES ❑NO

Are there any concerns about your child's growth and development? _____

_____

HEALTH HISTORY

Does your child ever complain of back or neck pain? ❑YES ❑NO

Does your child ever complain of pain in their arms or legs? ❑YES ❑NO

Does your child ever complain of headaches? ❑YES ❑NO

Has your child ever had earaches? ❑YES ❑NO

If yes: How frequently do they occur? _____

Do they tend to occur in the same ear? Right or left? _____

Which of the following has your child experienced? Indicate "C" (current) or "P" (past):

( ) ADD/ADHD
( ) Allergies
( ) Asthma
( ) Autism Spectrum Disorder
( ) Bed Wetting
( ) Bronchitis
( ) Bruising
( ) Chicken Pox
( ) Colic
( ) Constipation
( ) Diaper Rash
( ) Diarrhea
( ) Difficulty Sleeping
( ) Digestive Issues
( ) Frequent Infections
( ) Growing Pains
( ) Impetigo
( ) Learning Disability
( ) Measles
( ) Mononucleosis
( ) Nausea/Vomiting
( ) Pneumonia
( ) Seizures
( ) Sinus Issues
( ) Skin Condition
( ) Strep Throat
( ) Thrush
( ) Upper Respiratory Infection
( ) UTI

Has your child had any other illnesses? Please list each illness and its approximate date. _____

_____

Is your child presently receiving any medications? ❑YES ❑NO

If yes, please list the medication(s): _____

Has your child ever been to a hospital or emergency room? ❑YES ❑NO

If yes, explain: _____

Has your child recently been vaccinated? ❑YES ❑NO

If yes, please list the vaccination(s): _____

Do you have any other concerns about your child's health? _____

_____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a mutual understanding between provider and patient.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ **Date: _____/_____/_____**

Relationship to Patient: _____