CALZARETTO CHIROPRACTIC CENTER AGES 0-9

Patient Name_____ Name of Parents/Guardians_____

Address (City State Zip) _____

Home Phone:_____ Parent Cell: _____

Parent Email:_____

Patient Birth Date:___/___/___ Sex:_____ Weight:_____ Height:_____

Number of siblings:_____

How did you hear about our office? _____

If your child has no symptoms or complaints, and is here for wellness services, please check here ☐ herwise please briefly describe the reason for seeking chiropractic care:_____

_____

Name of other Doctors seen for this condition &prior treatment:

_____

_____

Has your child ever suffered from (in the past or currently): (Check all that apply)

◯ Dizziness	◯ Scoliosis/Postural Problems	◯ Behavioral Problems
◯ Diabetes	◯ Poor Appetite	◯ Ear Infections
◯ Neck Pain	◯ Bed Wetting	◯ Constipation
◯ Back Pain	◯ Fainting/Seizures	◯ Diarrhea
◯ Joint Problems	◯ Cardiac Issues	◯ Stomach Aches
◯ Broken Bones	◯ Asthma	◯ Persistent Gas
◯ Growing Pains	◯ Allergies	◯ Colic
◯ Walking Problems	◯ Sinus Trouble	◯ Latching Issues
◯ Arm/Leg Pain	◯ Frequent congestion	◯ Other_____
◯ Headaches	◯ Frequent Colds	

Previous Chiropractor: _____ Date of last visit:___ /___ /___

Reason:_____ Name of Pediatrician: _____ Date of last visit:___ /___ /___

Reason: _____

Are you satisfied with the care your child received there? ____N ____Y

Number of doses of antibiotics your child has taken:

During the past 6 months:_____ Total during his/her lifetime:_____

Number of doses of other prescription medications your child has taken:

During the past 6 months:_____ Total during his/her lifetime:_____

Please list all medications your child is taking or has taken:

_____

Please list any supplements/vitamins your child is taking:

_____

Does your child consume: Soda _____ Fast or Fried Foods _____ Dairy/Milk Products _____

Juice _____White Flour_____

Vaccination history: _____

Prenatal History for this child:

Location of Birth: Home/Birthing Center/Hospital (CNM or OB?)

Name of attendant: _____

Complications during pregnancy: ____N ____Y List: _____

Medications during pregnancy OR delivery:

_____

List any complications during delivery: How long was the labor? _____

Birth: Forceps _____Vacuum _____ Emergency C-section _____ Planned C-section _____

Weeks Gestation: _____ Birth weight_____ Birth length_____

APGAR scores_____,_____ N

Number of previous pregnancies: _____ Were there any problems? _____

Feeding history for this child:

Breast Fed: ____N ____Y How long? _____Any problems? _____

Formula fed: ____N ____Y How long? _____Type: _____

Did your baby have colic and/or reflux? ____ N ____Y Introduced to solids at ____months, Cow's milk at____ months

Food / juice allergies or intolerances _____N _____Y List: _____

Developmental History

Number of hours sleeping per night: _____Quality of sleep: _____Good _____Fair _____Poor

When did they stop napping (if so) _____

At what age was your child able to:

Respond to sound _____

Hold head up _____

Cross crawl _____

Stand alone _____

Sit Up _____

Walk alone _____

Respond to visual stimuli _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child? _____N _____Y

Is / has your child been involved in any sports? _____N_____Y Type: _____

Has your child ever been involved in a car accident? _____N ____Y Date: _____

Has your child been seen on an emergency basis? ____N ____Y Reason and Date: _____

Other traumas not described above, including falls from a height over 3 feet? _____

Prior surgery: ____N ___Y Type and Date: _____

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

_____

Insurance: Do you have medical insurance? ____N ____Y Insurance Company Name _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS. AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed Date: _____