BLOCK FAMILY CHIROPRACTIC

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Child's Name:___________________________________ Date of Birth: ____________________________________

Mother's Name: _________________________________ Occupation: _____________________________________

Father's Name: _________________________________ Occupation: ______________________________________

Address: ____

City: ____ Zip Code ______________________________________

Telephone (Home): ______________________________ Telephone (Work): ________________________________

Telephone (Mobile): _____________________________

E-Mail Address: ________________________________

Primary Care/Pediatrician Name: ____

Primary Care/Pediatrician Address: ____

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Primary Care/Pediatrician Phone Number & Email Address: ____

May we contact them in order to coordinate Care? (Circle): Y / N

How did you hear about us? ____

Health Insurance? Y /N Health Insurance Company? ____

Siblings? (Circle) : Y / N

(Name) _______________________________________ (Age) ____

(Name) _______________________________________ (Age) ____

Present Complaint or Concerns: (Aside from Wellness Care) ____

____

____

Have you consulted anyone else? Y / N

If yes, please list provider/s: ____

Is your baby on any medication? Y / N

If yes, please list medication/s: ____

Has your baby had any medical treatment / scans / x-rays / surgery? Y / N

If Yes, please list procedure/s: ____

Are you aware of any congenital disorder / birth defects? Y / N

If yes, please explain: ____

Any family history of illness? Y / N

If Yes, please explain: ____

Has your baby had any childhood illnesses / injuries / allergies? (Circle): Y / N

If Yes, please explain: ____

Does your child have any feeding / eating difficulties? Y / N

If Yes, please explain: ____

Has your child been checked for tongue / lip/ cheek ties? (Circle): Y / N

If Yes, please explain:____

Is your child vaccinated? (Circle): Full Schedule / Delayed / None / Undecided

Vaccine Questions or Concerns? ____

Reactions? ____

How long does your child normally sleep? ______________________________________

Use a pacifier? Y / N   Constant crying? Y / N   Sleep on their back? Y / N

Easy to sleep? Y / N   Arch their back? Y / N   Reflux / Colic / Constipation? Y /N

Does your child have a head preference?   Right   Left   No

How much tummy time does your baby get currently? ____

What are your goals for chiropractic care? ____

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PRENATAL / BIRTH

Did mother receive chiropractic care throughout the pregnancy? (Circle) : Y / N

Did mother have any illnesses or medications during pregnancy? (Circle) : Y / N

If yes, please explain: ____

Number of previous pregnancies _____________ Number of ultrasounds? _______________

Breech or Transverse Presentation? (Circle): Y/ N Face or Forehead Presentation? (Circle) Y / N

Weeks gestation at birth? __________________ Duration of birth? __________________

Was the birth premature / induced? (Circle) Y / N If yes, explain ____

Any interventions? (Circle) Y / N * Including vacuum extraction, forceps, epidural, episiotomy, etc. If yes, please explain: ____

Was the birth vaginal or cesarean? ______________If cesarean, was it planned or emergency? _________________

APGAR at birth? ____________ Jaundice? (Circle) Y / N NICU? (Circle): Y / N

Is your child breastfed, bottle fed, formula fed, or a mixture? ____

Has your child been introduced to solids? (Circle): Y / N

If yes, please list solids and age of introduction here: ____

Are you concerned with your child reaching their neurodevelopmental milestones? ____________________________

Parental Consent:

- ♦ I have received a full explanation of my child's condition □
- ♦ I have had the opportunity to ask questions □
- ♦ I have been advised of options, benefits and possible side effects to care □

I, ___________________________, hereby give my consent for my child, _________________, to be examined by the Chiropractor using chiropractic methods as seen fit.

Parent / Guardian ………..………………………………………………………………………………......
(Signature)

Signed ……………………………………………..………………….. Date……………………………
(Print Name)