# *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: _____

_____

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)