clearfield chiropractic

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INFANT/CHILD INFORMATION

Name_____ Date _____ Referred by_____
First MI Last
Address_____ City/State/Zip_____

Social Security #_____ Birth Date _____ Gender: Male___ Female___

Mother's Name_____ Phone # (H)_____ (W)_____
Address (if different) _____ Cell # _____
Social Security #_____ Date of Birth_____
Employer_____ Occupation_____

Father's Name_____ Phone # (H)_____ (W)_____
Address (if different) _____ Cell # _____
Social Security #_____ Date of Birth_____
Employer_____ Occupation_____
*Contact Email (Parent or Guradian_____

***Purpose of this appointment**_____
Relief for a specific injury or condition_____ Maintaining a healthy lifestyle_____
Improving your overall health without drugs or surgery_____ Prevention of illnesses_____

PAST HISTORY

Was the pregnancy: full-term / premature? *(circle one)* If premature, how early?_____
Mother's medications during pregnancy_____
Was labor induced? YES / NO How long was labor?_____ Vaginal delivery / C-section? *(circle one)*
Baby's presentation at time of birth: ___head-first ___breach ___other:_____
Were forceps or suction used on the baby any time during delivery? YES / NO
If so, explain: _____

Obstetrician_____ Pediatrician_____ Other_____
Previous chiropractor_____ For what reason_____
Frequency of previous chiropractic care_____ Date of last adjustment_____
Child's current medications_____
Any previously diagnosed conditions_____
Has your child been vaccinated? YES / NO Were there any side effects or complications noticed with any of them? YES / NO
If so, please explain_____
Was your child breast fed? YES / NO If so, for how long?_____
Please list child's allergies or food sensitivities_____
List any injuries or accidents & give dates_____
List any surgeries or procedures & give dates_____
Additional comments relating to your child's symptoms(s) or health concerns:

_____

_____

(PLEASE FILL OUT BACK OF FORM)

PAST & PRESENT CONDITIONS

(Please X all that apply)

___Neck pain
___Allergies
___Sinus problems
___Headaches
___Ear infections
___Convulsions/seizures
___Frequent colds/flus
___Mental/emotional disorders
___Other:_____

___Mid back pain
___Sleep disorders
___ADHD
___Colic
___Asthma
___Digestive problems
___Visual problems/dizziness
___Growing pains
___Other:_____

___Low back pain
___Diarrhea/ Constipation
___Kidney/bladder infections
___Bed-wetting
___Heart condition
___Diagnosed scoliosis
___Family scoliosis
___Fractured bones
where:_____

EXAM

Head Rotation	None	Lt / Rt
Head Tilt	None	Lt / Rt
High Shoulder	Even	Lt / Rt
Genu Vargus	None	Lt / Rt
Genu Valgus	None	Lt / Rt

Leg Length (short)	Even	Lt / Rt
Performed	Prone / Supine	
Toe Flare	None	Lt / Rt
Acetabular Pump	Even	Lt / Rt

NOTES: