

# Complete Chiropractic



5930 Hamilton Blvd.  
Unit 8  
Allentown, P A 18106  
(610)841-2204

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ SSN: \_\_\_\_\_ Birth Date: \_\_\_\_\_  Male  Female

Pediatrician/Family Doctor: \_\_\_\_\_ Reason for consulting our office:

\_\_\_\_\_  
\_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## Health Profile

### Why is this form important?

As a family chiropractic office we focus on your child's ability to be healthy. Our goals are first to address the issues that brought you to this office, and second, to offer you and your child - the opportunity of improved health potential and wellness services.

## Addressing The Issues That Brought You to the Office

If your child has no symptoms or complaints, and is here for wellness services, please check ; others need to briefly describe the chief area of complaint, including the effect it has on the child.

If he/she is experiencing pain, is it  Sharp  Dull  Comes and Goes  Travels  Constant Since the problem started, is it:  About the same  Getting better  Getting worse?

What makes it worse? \_\_\_\_\_

It interferes with:  School  Sleep  Walking  Sitting  Hobbies  Other: \_\_\_\_\_

Other doctors seen for this problem:

Chiropractor: \_\_\_\_\_ Date(s): \_\_\_\_\_

Medical doctor: \_\_\_\_\_ Date(s): \_\_\_\_\_

Other: \_\_\_\_\_ Date(s): \_\_\_\_\_

List medications the child is taking or surgeries the child has had:

\_\_\_\_\_

\_\_\_\_\_

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to you child's health potential.

**Pregnancy:**

Were there any complications to the pregnancy? \_\_\_\_\_

Was Mom on any medications, prescription or over-the-counter?  Yes  No

If yes, explain: \_\_\_\_\_

Did Mom or Dad smoke during pregnancy?  Yes  No Who? \_\_\_\_\_

Was the baby ever in the Breech position?  Yes  No

How many ultrasounds were performed? \_\_\_\_\_

**Birth and Delivery**

Where was the baby born?  Home  Hospital  Birthing Center  Other: \_\_\_\_\_

Was the delivery:  Vaginal  C-section Were any devices used?  Forceps  Vacuum

How long was the labor? How long was the delivery? \_\_\_\_\_

Was oxytocin/pitocin used? Yes No Was an epidural administered?  Yes  No

**Infancy:**

Was the infant vaccinated?  Yes  No

Was there any prolonged use of medicines or an inhaler?  Yes  No If yes, which: \_\_\_\_\_

Did the infant suffer any traumas such as serious falls or car accidents?  Yes  No

Has the infant been under regular chiropractic care?  Yes  No

**Childhood years:**

Did the child have any childhood illnesses?  Yes  No Explain: \_\_\_\_\_

Does the child play youth sports?  Yes  No Which sport(s)? \_\_\_\_\_

Has the child had any surgery?  Yes  No Explain: \_\_\_\_\_

Has the Child fallen from a height over 3ft?  Yes  No Explain: \_\_\_\_\_

Was the child involved in any car accidents?  Yes  No When? \_\_\_\_\_

Has there been any prolonged use of medication?  Yes  No Explain: \_\_\_\_\_

Has the child suffered emotional traumas?  Yes  No Explain: \_\_\_\_\_

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

\_\_\_\_\_

I have read and completed all answers to the above questions to the best of my knowledge. I am aware that answering yes to any of the above questions may require my child to undergo further testing prior to starting any appropriate care. I hereby give my full consent to undergo a care program designed for my child if determined to be clinically medically necessary by my doctor. I will notify them of any changes in my child's health status during the duration of the program. It is also my duty to daily inform the doctor or assistant of any possible complication prior to the initiation of my child's daily treatment.

Your signature \_\_\_\_\_ Date \_\_\_\_\_

Physician signature \_\_\_\_\_ Date \_\_\_\_\_