

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

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 _____