Welcome (Ages 0-5)

Crouch FAMILY CHIROPRACTIC

Patient Information	Today's Date:

Birth Date:_____ Sex: ☐ Male ☐ Female SSN_____

Last Name _____ First Name _____ Middle Initial _____Nickname _____

Address: _____ City: _____ State: _____ Zip _____

Referred By _____Spoken Language:_____ Race:_____ Ethnicity:_____

Mother's Name: _____ Father's Name: _____ Guardian _____

Phone # (Best to Reach): _____Phone (Other): _____Parent's Email:_____

Emergency Contact_____Phone Number: _____Would you like to receive our newsletter? ☐ Yes ☐ No

Method of Payment: (Please circle) Insurance, Self Pay, Care Credit, Med-pay, Other _____

Has your child ever had chiropractic care before? **Y / N** For what problem _____Were the results satisfactory? **Y / N**

Any previous spinal x-rays, MRIs? **Y / N** Pediatrician:_____

The reason for today's visit is: _____

_____

Parent's (Guardian's) Signature for Consent to Evaluate Minor: _____

We want you to have a copy of your child's "Summary of Patient Health Information"
This is specific health history information (from our office) and keeps you up to date on what we have on file.
You will get one email with a secure link to our software. Use this link anytime you want to access your health information.
Please make sure we have your email address (above).
You will need a password to access your account. This will be your last name (lowercase) + last 4 digits of SS# _____

As a full spectrum Chiropractic office, we focus on you and your child's ability to be healthy. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses your child has faced during his/her lifetime, allowing us to better assess the challenges to your child's health potential.

Any Surgeries	Broken Bones	Trauma History	Vitamins	Current Meds	Allergies
_____	_____	Car Accidents	_____	Please list medications and dosage.	List any allergies and Severity. (Mild, Mod, Sev)
_____	_____	_____	_____		
_____	_____	_____	_____	_____	_____
_____	Implants	_____	_____	_____	_____
_____	_____	Serious Illnesses	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Family History:

Did / Does your Mother (M) or Father (F) have any of the following?

☐ High Blood Pressure (M / F) ☐ Heart Attack (M / F) ☐ Emphysema (M / F) ☐ Seizures – Convulsions (M / F)

☐ Asthma (M / F) ☐ Diabetes (M / F) ☐ Kidney Disease (M / F) ☐ Pace Maker (M / F)

☐ Ulcers (M / F) ☐ Arthritis (M / F) ☐ Stroke (M / F) ☐ Digestive Troubles (M / F)

☐ Mental Illness (M / F) ☐ Thyroid (M / F) ☐ Cancer (M / F) ☐ Osteoporosis (M / F)

Please list any other health challenges / problems in your family history:

_____

_____

THE BEGINNING YEARS (Answer what you can remember)

Patient Initials:

BIRTHING PROCESS:

Where did delivery take place? ☐ Home ☐ Medical /Hospital _____ ☐ Birthing Center _____

Did you use a: ☐ Midwife ☐ Doula

Duration of Pregnancy: _____weeks

Were any other means used during the birthing process:
☐ NO ☐ YES,circle? Induced Forceps Vacuum Extraction C-section Other_____

Duration of Birth:_____ Medications delivered at birth: ☐ NO ☐YES,explain? _____

Was Delivery Normal? ☐ YES ☐ NO, explain?_____

APGAR at birth _____ After 5 mins._____ BIRTH WEIGHT: _____ BIRTH LENGTH:_____

GROWTH AND DEVELOPMENT:

Was the infant alert and responsive within twelve hours of delivery □YES □NO, explain? _____

_____

AT WHAT AGE DID YOUR CHILD:

Respond to Sound_____ Follow an object_____ Hold up head_____
Vocalize_____ Sit Alone_____ Teethe_____ Crawl_____ Walk_____

Do sleeping patterns seem to be normal? ☐YES ☐ NO, explain?_____

Any health problems on:

Mother's side of the family? ☐ NO ☐ YES, explain?_____

Father's side of the family? ☐ NO ☐YES, explain?_____

With brothers or sisters? ☐ NO ☐ YES, explain? _____

Physical / Traumatic Stressors

Any traumas during pregnancy (falls, accidents)?_____

Any evidence of birth trauma: (circle any that apply)

Bruises Odd shaped head Stuck in birth canal Fast birth Excessively long birth

Respiratory depression Discoloration Cord around neck

Any falls from couches, beds, changing tables, chairs? ☐ NO ☐ YES, explain?_____

_____

Any surgeries? ☐ NO ☐ YES, explain? _____

Play any sports? ☐ NO ☐ YES, which ones?_____

ANY OTHER PHYSICAL STRESSORS?

Emotional Stressors

Any difficulties with lactation? ☐ NO ☐ YES

Any problems with bonding? ☐ NO ☐ YES

Any behavioral problems? ☐ NO ☐ YES, how & when did they begin?_____

Any difficulty sleeping? ☐ NO ☐ YES,explain? _____

Age when child began daycare?_____

Average number of hours of television per week?_____

Does your child seem normal for his/her age? ☐ YES ☐ NO, explain?_____

ANY OTHER EMOTIONAL STRESSORS?

Chemical Stressors

Patient Initials:

Was this baby breast-fed? ☐ NO ☐ YES, how long?_____ Still being breast fed? ☐ NO ☐ YES

Formula introduced at age_____ Type of formula used_____

Introduction to cow's milk at age_____ Began solid foods at age_____

Type of solid food _____ Commercial baby food introduced When?_____

FOOD/JUICE intolerance ☐ NO ☐ YES, explain? _____

During pregnancy did the mother: Smoke?☐ NO ☐ YES Drink alcohol?☐ NO ☐ YES Drink caffeine?☐ NO ☐ YES

Any illnesses of the mother during pregnancy? ☐ NO ☐ YES, explain?_____

Any supplements during pregnancy? ☐ NO ☐ YES, explain?_____

Any drugs (prescription, over-the-counter, recreational) taken during pregnancy? ☐ NO ☐ YES_____

Any ULTRASOUNDS during pregnancy ☐ NO ☐ YES, how many and list medical reason?_____

Any invasive procedures (amniocentesis)? ☐ NO ☐ YES, list?_____

Any pets at home? ☐ NO ☐ YES, what kind and how many?_____

Any smokers that live in the home? ☐ NO ☐ YES, IF YES, HOW MUCH DO THEY SMOKE?_____

Any Vaccinations? ☐ NO ☐ YES – ALL to Date ☐ Yes - Some, List _____

Any antibiotics use ☐ NO ☐ YES, when was first course of antibiotics given?_____

TOTAL number of courses of antibiotics give to date?_____

ANY OTHER CHEMICAL STRESSORS?_____

If Your Child has Pain – Please mark the Chart Below – IF NOT LEAVE BLANK
(If you need help please ask the front desk)

Onset Date

_____

Exacerbated

_____

Type:

Pain, Numbness
Swelling
Muscle Spasms
Headache
Tightness
Stiffness
Tingling, Weakness

Quality

Sharp, Dull, aching, throbbing, crushing, stabbing, local, radiating, migraine, tension,hormonal, sinus, Other

Location

Front

Back

Timing

Constant
Frequent
Intermitt
Occasion
Infrequent

Severity

Mild
Tolerable
Moderate
Severe
Disabling

% Awake

Please list any additional information you would like us to know about your child:

_____
_____
_____
_____
_____
_____
_____
_____
_____