BEARD CHIROPRACTIC FAMILY WELLNESS CLINIC

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BIRTH – 2 YEARS CONFIDENTIAL PATIENT INFORMATION

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

Today's Date:_____

PATIENT INFORMATION:

Child's Name:_____ Child's Nickname:_____

Reason for visit:_____

Child's Address and Phone (if different from yours)_____

Sex: M / F Birthdate:_____ Age:_____ Who may we thank for referring you?_____

FAMILY INFORMATION:

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

Address:_____ Address: _____

Home & Work Phone:_____ Home & Work Phone_____

Parents Marital Status: Mar ____ Sing ____ Div ____ Wid ____ Main language at home:_____

List ages of other children in family:_____

PAYMENT INFORMATION:

If you have insurance that may cover chiropractic services, please provide you current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for the child's health insurance coverage.

Insured's Name:_____Birth Date:_____ SSN:_____

Employer: _____Group#: _____ Insured's ID:_____

CONSENT TO TREAT:

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son / daughter named _____ as the examining / treating doctor deems necessary.

I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Parent's Name Printed:_____Signature:_____

Date: _____Witnessed by:_____

BIRTH HISTORY:

LABOR AND DELIVERY:

How long was the labor from the first regular contractions to the birth?_____hours.
How long was the 2nd stage (the pushing phase) of the labor?_____hours.
Was birth Vaginal _____ or C-Section _____ Was birth induced (pitocin)?_____
Were extraction methods used?_____
During pregnancy did you use and of the following:

Tobacco?	☐	☐	_____
Alcohol?	☐	☐	_____
Non-prescription drugs?	☐	☐	_____
Prescription medications?	☐	☐	Med(s) _____ Reason _____
Over-the-counter meds?	☐	☐	Med(s) _____ Reason _____

INFANT HISTORY:

The following questions are designed to help the doctor provide the best possible spinal care for your child

How many hours does your baby sleep between feeds? During the day_____ At night _____

Use lines to explain answers if necessary ⇩

Yes	No	
☐	☐	Does your child go to sleep easily?_____
☐	☐	Does your child have a preferred sleeping position?_____
☐	☐	Does your child cry if you change this sleeping position?_____
☐	☐	Does your child have any feeding difficulties?_____
☐	☐	Does your child frequently spit-up after feeding?_____
☐	☐	Has your child had colic? _____
☐	☐	Is your child being breast fed? If no, for how long was baby breast fed _____ weeks/months.
☐	☐	Does your child have a one sided breast-feeding preference? Left / Right (Please circle one)
☐	☐	Is your child formula fed? Which formula or other milk source?_____
☐	☐	Is your child eating solid food? If so, which foods? _____
		What is your child's favorite food? _____
☐	☐	Is your child receiving any vitamin supplements? _____
☐	☐	Does your child cry a lot? For how many hours each day?_____
☐	☐	Does your child have a preferred head position?_____
☐	☐	Does your child frequently arch his/her head and neck backward?_____
☐	☐	Does your child cry or become irritable during a diaper change?_____

TRAUMA:

⇩

Yes	No	
☐	☐	Has your child had any falls? _____
☐	☐	Has your child ever had a bone fracture or joint dislocation (Where) _____
☐	☐	Has your child ever fallen down stairs or fallen from any height? (Where/When) _____
☐	☐	Has your child been in a car accident or near-miss?_____
☐	☐	Has your child had any other trauma or injuries?_____
☐	☐	Does your child ever bang his/her head repeatedly against a wall or other object? _____
☐	☐	Has your child been vaccinated?_____
☐	☐	Do you have any other concerns you wish to discuss?_____

GROWTH AND DEVELOPMENT:

Yes	No	
☐	☐	Can your child sit unsupported? _____ At what age did your child start to sit-up? _____ months
☐	☐	Is your child crawling yet? _____At what age did your child start crawling? _____months
☐	☐	Is your child walking yet? _____ At what age did your child start walking? _____months
☐	☐	Does your child often trip and fall? _____
☐	☐	Do you have any other concerns about your child's growth and development? _____

HEALTH HISTORY:

Yes	No	
☐	☐	Has your child ever had a fever?_____
☐	☐	Has your child had any upper respiratory infections? How often?_____
☐	☐	Has your child had asthma? _____
☐	☐	Has your child had any earaches? _____ At what age did the first earache occur? _____
☐	☐	How frequently does your child have earaches? _____
☐	☐	Do your child's earaches usually tend to occur in the same ear? _____Is it the right or left ear? _____
☐	☐	Has your child had any other illnesses? _____ Please list each illness and its approximate date

_____

☐	☐	Is your child presently receiving any medications? _____
☐	☐	Does your child have any medication allergies? _____ To what? _____
☐	☐	Has your child ever been to a hospital or emergency room for evaluation or treatment? _____
☐	☐	Does your child pass a lot of intestinal gas? _____
☐	☐	Does your child have any digestive disturbances? _____
☐	☐	Does your child have any food allergies? _____ To what? _____
☐	☐	Does your child have any environmental allergies? _____ To what? _____
☐	☐	Does your child have any persistent or intermittent skin rashes? _____
☐	☐	Do you have any other concerns about your child's health? _____