Dr. Meghan's Healing Hands Chiropractic Ages 0-9

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.

Patient Name_____Name of Parents/Guardians_____

Address_____City_____State_____Zip___Parent Cell Phone_____

Parent Email:_____ Patient Birth Date_____/_____/_____

Sex_____ Weight_____ Height_____ Number of siblings_____

How did you hear about our office? _____

If your child has no symptoms or complaints, and is here for wellness services, please check here ☐ Otherwise please briefly describe the reason for seeking chiropractic care:_____

_____

Name of other Doctors seen for this condition & prior treatment: _____

Has your child ever suffered from (in the past or currently): (Check all that apply)

☐ Dizziness	☐ Walking Problems	☐ Cardiac Issues	☐ Ear Infection
☐ Diabetes	☐ Arm/Leg Pain	☐ Asthma	☐ Colic
☐ Neck Pain	☐ Headaches	☐ Allergies	☐ Constipation
☐ Back Pain	☐ Scoliosis/Postural Issues	☐ Sinus trouble	☐ Diarrhea
☐ Joint Problems	☐ Poor Appetite	☐ Frequent Congestion	☐ Stomach Aches
☐ Broken Bones	☐ Bed Wetting	☐ Frequent Colds	☐ Persistent Gas
☐ Growing Pains	☐ Fainting/Seizures	☐ Behavioral Problems	☐ Other:_____

Previous Chiropractor: _____ Date of last visit _/___/__

Reason: _____

Name of Pediatrician: _____ Date of last visit /___/____

Reason: _____

Are you satisfied with the care your child received there? ____N ____Y

Number of doses of antibiotics your child has taken:

During the past 6 months_____ Total during his/her lifetime_____

Number of doses of other prescription medications your child has taken:

During the past 6 months_____ Total during his/her lifetime_____

Please list all medications your child is taking or has taken: _____

Please list any supplements/vitamins your child is taking: _____

Does your child consume: Soda _____ Fast or Fried Foods _____ Dairy/Milk Products _____Juice _____White Flour_____

Vaccination history:_____

Prenatal History for this child:

Location of Birth:_____Home____Birthing Center____Hospital (CNM or OB?) Name of attendant: _____

Complications during pregnancy: ____N ____Y List:_____ # of Ultrasounds_____

Medications during pregnancy OR delivery: _____

List any complications during delivery:_____How long was the labor?_____

Birth: Forceps _____Vacuum _____ Emergency C-section _____ Planned C-section _____

Weeks Gestation: _____ Birth weight_____ Birth length_____ APGAR scores_____,_____

Number of previous pregnancies: _____ Were there any problems? _____

Feeding history

Breast Fed: ____N ____Y How long?_____Any problems? _____

Formula fed: ____N ____Y How long?_____Type:_____

Did your baby have colic and/or reflux? _____ N _____Y Introduced to solids at_____months, Cow's milk at_____months

Food / juice allergies or intolerances _____N _____Y List: _____

Developmental History

Number of hours sleeping per night:_____Quality of sleep: Good Fair Poor

When did they stop napping (if so) _____

At what age was your child able to:

_____ Respond to sound _____ Cross crawl _____ Sit Up

_____Respond to visual stimuli _____ Stand alone

_____ Hold head up _____ Walk alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child?_____N_____Y

Is / has your child been involved in any sports?_____N_____Y Type: _____

Has your child ever been involved in a car accident? _____N ____Y Date:_____

Has your child been seen on an emergency basis? ____N ____Y Reason and Date: _____

Other traumas not described above, including falls from a height over 3 feet? _____

Prior surgery: ____N ___Y Type and Date:_____

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

_____

Insurance:

Do you have medical insurance? ____N ____Y Insurance Company Name _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed_____ Date: _____