

Chiropractic First
Child's Information Form

Child's Name: _____ Parents' Names: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Birth Date: _____ Age: _____ Sex: M / F Current Weight _____

Type of Birth: Normal Vaginal _____ Cesarean _____ Breech _____ Forceps _____
Suction Cap/Vacuum Extractor _____ Home _____ Birthing Center _____ Hospital _____
Problems during pregnancy _____
Problems during labor/delivery _____
Length of labor _____

Check all that apply concerning your labor:

Position during labor? On Back _____ Side, sitting or standing _____

Receive drugs? Epidural _____ Morphine _____ Other _____

Monitoring Child? Internal _____ External _____

Induced Labor? YES / NO Episiotomy? YES / NO

Was your child subjected to: Drops in eyes? YES / NO Vitamin K? YES / NO

Hepatitis Shot? YES / NO Incubation? YES / NO If yes, how long? _____

Separation from you? YES / NO If yes, how long? _____

Congenital anomalies/defects: _____

Infant feeding: Breast _____ Formula _____

of hours sleep per night: _____ Quality of sleep: Good _____ Fair _____ Poor _____

Obstetrician/Mid-Wife: _____

Pediatrician/Family MD: _____

Date of last visit to MD: _____ Purpose: _____

Vaccination History: _____

Why were shots given? _____

Has your child been treated on an Emergency Basis? _____

Describe: _____

Surgeries: _____

List any over the counter or prescription drugs your child is taking: _____

Has your child ever been under Chiropractic Care previously? YES / NO

If yes, Name of Chiropractor: _____

Has your child ever had a fall:

Off a change table: YES / NO, Out of a crib: YES / NO, Off a jolly jumper: YES / NO,

Down stairs: YES / NO, Out of a tree: YES / NO, Off a bike: YES / NO

Has your child ever been in a car accident? YES / NO If yes, please describe: _____

Purpose of today's appointment: _____

Authorization for Chiropractic Care of a Minor

I hereby authorize this office and it's doctor(s) to administer care as deemed necessary to my son/daughter _____ (name of child). I realize that I am responsible for all fees charged by this office and that I will pay for all services as they are performed.

Signature: _____ Witnessed: _____ Date: _____