Zavitz Family Chiropractic

Our mission is to help all people achieve their maximum Health potential, especially children. We believe the foundation of a healthy body and healthy life starts as soon as we are born and is our most valuable asset as we walk through life.

Patient Information

Patient Name: _____

Address: _____ City:_____ Postal Code:_____

Birth Date: Day:_____ Month:_____ Year:_____

Who referred you to our clinic? _____

Parent/Guardian Information

Moms Name:_____ Dads Name:_____ Other:_____

Occupation:_____ Employer:_____

Home Phone:_____ Cell Phone:_____ Other Phone:_____

Marital Status:_____ Email Address:_____

Health Care History

Has your child had **chiropractic care** before?_____ Last Visit:_____

Where/Who?_____ Reason for visit:_____

Reason for leaving:_____

Where Xrays taken?_____ Date:_____

Present **MD/Pediatrician** Name:_____ Date Last visit:_____

Reason for last visit:_____

Pregnancy and Birth: for MOMS

Tell us about your pregnancy and birth of this child:_____

_____

Did you use a midwife?_____ Hospital?_____ Obstetrician?_____

Did you have a C-section?_____ Were forceps used?_____ Vacuum Extraction?_____

Were you induced?_____ Did you have an epidural?_____ Was it a difficult birth?_____

Was your child born with a mis-shaped skull/head?_____

Baby/ Toddler Years (ages birth to 4 years)

As a baby/toddler (0-4 years), did any of the following occur?

- ☐ fall from change table
- ☐ tumble down stairs
- ☐ fall out of crib
- ☐ involved in car accident
- ☐ fall of playground equipment
- ☐ frequent ear infections
- ☐ frequent crying spells
- ☐ frequent diarrhea
- ☐ constipation

Baby/ Toddler Years (ages birth to 4 years) continued…

☐ Sleeping issues ☐ Colic ☐ Other

☐ Trouble Breast feeding ☐ Difficulty gaining weight

☐ Frequent Colds ☐ Failure to thrive

Please explain the above:_____

_____

Young Child (ages 5-12 years)

As a young child, (5-12 years), did any of the following occur?

☐ fall from tree ☐ Stomach pains ☐ asthma

☐ fall off bike ☐ scoliosis ☐ allergies

☐ fall off playground equipment ☐ bed wetting ☐ leg/knee pain

☐ sports accidents ☐ ADD/ADHD ☐ Other:_____

☐ car accident ☐ Learning disability

Please Explain the above:_____

_____

As a child or adolescent, has your child experienced any of the following?

☐ Headaches ☐ numbness in arms/legs ☐ Neck/ back pain

☐ Dizziness ☐ arm/wrist/ pain ☐ Shoulder pain

☐ Ringing in the ears ☐ sleeping problems ☐ Growing Pain

☐ Asthma ☐ Allergies ☐ Anxiety/ Depression

☐ Hyperactivity ☐ Stomach problems ☐ Other:_____

☐ Fatigue ☐ Foot/ankle/knee pain

Please explain the above:_____

_____

Which of the above problems you have checked off is the worst?_____

Is this problem: Constant ☐ intermittent ☐ occasional ☐ cyclical ☐

When did this problem first start?_____

Is this problem: Getting Better ☐ ☐ Staying the Same ☐ Getting worse

What makes it worse/ better?_____

What is the main purpose for your visit today? ☐ Wellness Care

_____

_____

_____

Medical Health History

Describe any hospital stays:_____

Approximately how many times have antibiotics been prescribed and for what conditions?_____

_____

List any Medications your child is currently taking:_____

Consent

Parent/Guardian Consent (For age 17 and under)

I_____ (Parent/Guardian) consent to the Chiropractic examination, treatment and x-rays (if necessary), of _____ (Child's Name) at Zavitz Family Chiropractic. Date:_____