Berkley CHIROPRACTIC

CARE FOR THE WHOLE FAMILY

It is our pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you and your family!

Patient Name _____ SS# _____

Name of Parents / Guardians _____

Address_____ City _____ State_____ Zip _____

Best Contact # Cell OR Home _____ Parent/Guardian Work # _____

Email _____

Patient Date of Birth _____ Sex M / F Height _____ Weight _____ # of Siblings _____

How did you hear about our office? _____

Reason for seeking chiropractic care _____

Other doctors seen for this condition (circle) Yes / No

If yes, doctor's names and prior treatment _____

Other health problems _____

Has your child ever suffered from (check all that apply)

- ☐ Dizziness
- ☐ Diabetes
- ☐ Arthritis
- ☐ Neuritis
- ☐ Anemia
- ☐ Poor Appetite
- ☐ Bed Wetting
- ☐ Fainting
- ☐ Neck Problems
- ☐ Joint Problems
- ☐ Backaches
- ☐ Tuberculosis
- ☐ Headaches
- ☐ Digestive Problems
- ☐ Rheumatic Fever
- ☐ Hyperactivity
- ☐ Convulsions
- ☐ Walking Problems
- ☐ Arm Problems
- ☐ Blood Disorders
- ☐ Heart trouble
- ☐ Hypertension
- ☐ Asthma
- ☐ Sinus Trouble
- ☐ Orthopedic Problems
- ☐ Paralysis
- ☐ Broken Bones
- ☐ Leg Problems
- ☐ Colic
- ☐ Stomach Aches
- ☐ Chronic earache
- ☐ Frequent Colds / Flu
- ☐ Allergies
- ☐ Constipation
- ☐ Diarrhea
- ☐ Behavioral Problems
- ☐ Muscle Jerking
- ☐ Ruptures/ Hernias
- ☐ "Growing Pains"
- ☐ Other _____

Family Health History

Previous Chiropractor(s) _____

Reason for Care _____

Are you satisfied with the care your child received there? Yes / No

Name of Pediatrician _____

Reason for Care _____

Are you satisfied with the care your child received there? Yes / No

Number of antibiotics your child has taken:

During the past 6 months _____ Total during his/her lifetime _____

Has your child ever taken any prescription medications? Yes / No

Current prescription medications _____ Previous prescription medications _____

Vaccination History _____

PRENATAL HISTORY

Type of Birth Attendant: OB/GYN / CNM / Lay Midwife Name _____

Location of Birth: Home / Birthing Center / Hospital

Complications during pregnancy: Yes / No List _____

Ultrasound during pregnancy: Yes / No Number _____

Medications during pregnancy / delivery: Yes / No List _____

Cigarette/ Alcohol use during pregnancy: Yes / No

Birth Intervention: Forceps / Vacuum / Caesarian Planned or Emergency? _____

Complications during delivery: Yes / No List _____

Genetic disorders or disabilities: Yes / No List _____

Birth weight _____ Birth length _____ APGAR scores _____

FEEDING HISTORY

Breast Fed: Yes / No How long? _____ Formula Fed: Yes / No How long? _____

Type _____ Introduced to solids at _____ months, Cow's milk at _____ months

Food/ juice allergies or intolerances: Yes / No List _____

DEVELOPMENTAL HISTORY

Number of hours sleeping per night _____ Quality of sleep: Good / Fair / Poor

At what age was your child able to:

_____	Respond to sound	_____	Cross crawl
_____	Respond to visual stimuli	_____	Stand alone
_____	Hold head up	_____	Cruise
_____	Sit 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? Yes / No

Is/has your child been involved in any high impact or contact type sport? Yes / No

Has your child ever been involved in a car accident? Yes / No

Other traumas not described above: Yes / No Date & Describe _____

Prior surgery: Yes / No Type and Date: _____ Menarche: _____

CHILDHOOD DISEASES

Chicken Pox	Y / N	Age _____	Mumps	Y / N	Age _____
Rubella	Y / N	Age _____	Whooping Cough	Y / N	Age _____
Rubeola	Y / N	Age _____	Other _____		

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 Doctor(s) 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.

Patient Name_____ Parent/Guardian's Name_____

Parent/Guardian's Signature_____ Date _____

Witnessed _____ Date _____