Complications during delivery? _____No _____Yes List:_____

Genetic Disorders or Disabilities: _____No _____Yes List:_____

Birth Weight:_____ Birth Length:_____ APGAR Scores:_____, _____

Was delivery within 2 weeks of due date? _____Yes _____No # of days premature / late:_____

Feeding History:

Breast fed: _____No _____Yes How long?_____

Formula fed: _____No _____Yes How long?_____ Type:_____

Introduced to solids at: _____months; Cow's Milk at _____months

Food / Juice Allergies or Intolerances: _____No _____Yes List:_____

_____

Developmental History:

During the following times your child is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____Respond to Sound
_____Respond to Visual Stimuli
_____Hold Head Up
_____Sit Up
_____Cross Crawl
_____Stand Alone
_____Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their 1st year of life (i.e. a bed, changing table, stairs, etc.) Was this the case with your child? ___No ___Yes

Is / Has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.) _____No _____Yes List:_____

Has your child ever been involved in a car accident? _____No ____Yes List:_____

Has your child been seen on an emergency basis? ____No ____Yes List:_____

Other traumas not described above? ____No ____Yes List:_____

Prior surgery: _____No ____Yes List:_____

Menarche: _____No _____Yes Age:_____

Childhood Diseases:

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

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 for 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: _____ Relationship to patient:_____ Date:_____/_____/_____