

CHILD'S INFORMATION

name:

address:

city:

zip/state:

parent's home phone:

parent's work phone:

parent's email address:

date of birth:

gender:

male female

weight:

name of parent(s)/ guardian(s):

how did you hear about our office?

MEDICAL HISTORY CONT.

childhood illnesses:

chicken pox ___ age mumps ___ age rubella ___ age
 whooping cough ___ age rubeola ___ age other ___ age
 if other, please list:

are you content with your child's present level of health? YES NO
 explain:

is your child currently taking any medications? YES NO
 if yes, please list along with reason why:

has your child taken any medication for an extended period of time in the past? YES NO
 if yes, please list along with reason why:

does your child take any herbal or vitamin supplementation? YES NO
 if yes, please list:

number of doses of antibiotics your child has taken:
 during past 6 months: _____
 during his or her lifetime: _____
 list:

number of doses of other prescription medications your child has taken:
 during past 6 months: _____
 during his or her lifetime: _____
 list:

has your child received vaccinations? YES NO

MEDICAL HISTORY

purpose for contacting us?

how long has your child experienced this?

is it getting better or worse over time?

other health care professionals consulted:

other health problems?

select any of the following that your child experiences or has experienced in the past:

ear infections asthma/allergies allergies sinus troubles
 chronic colds recurring fevers seizures headaches
 back pains neck pains bed wetting constipation/diarrhea
 bronchitis/upper respiratory infections ADD/ADHD
 other _____

PRENATAL HISTORY

ultra sound during pregnancy? YES NO

medications during pregnancy? YES NO

medications during labor/delivery? YES NO

were you induced? YES NO

was your delivery a c-section? YES NO
if yes, was it planned or emergency?
 planned emergency

were any of the following used during delivery?
 forceps vacuum extraction other
if other, please list:

any complications during delivery? YES NO
if yes, please explain:

location of birth: hospital birth centre home

weight at birth: _____ length at birth: _____

DEVELOPMENTAL HISTORY

at what age was your child able to:

hold head up: _____

sit-up: _____

crawl: _____

walk alone: _____

has your child ever fallen from a high place?
(bed, changing table, sofa, downstairs, etc.) YES NO
if yes, please explain:

is/was your child involved in any impact
or contact sports? YES NO
(soccer, football, gymnastics, baseball, roller or ice hockey)
if yes, please explain:

has your child ever been involved in a car accident?
if yes, please explain: YES NO

has your child ever been seen on an emergency basis?
if yes, please explain: YES NO

prior surgery? YES NO
if yes, please explain:

FEEDING HISTORY

breast fed: YES NO

if yes, how many months? _____

formula fed: YES NO

if yes, please explain? _____

introduced to solids at _____ months

cow's milk at _____ months

food sensitivities:

ADDITIONAL COMMENTS



CONSENT FOR CARE

Doctors of Chiropractic, Medical Doctors, and Physical Therapist using manual therapy treatments for patients with neck problems are required to explain that there has been rare cases of injury to a vertebral artery as a result in treatment. Such an injury has been known to cause stroke, sometimes with neurological injury. **The chances of this happening are extremely remote, approximately 1 per million treatments.**

Appropriate tests will be performed on your to help identify if you may be susceptible to that kind of injury. **Dr. Barron uses a variety of techniques in this office: many techniques do not involve manual therapy, especially those for infant, elderly, and pregnant mothers.** If you have any questions about this , please do not hesitate to speak with the doctor.

I understand that the spinal adjustments offered in this office are not a replacement for any form of treatment provided by other types of practitioners. I understand that I am not being treated for any symptoms or condition other than spinal subluxation. This office enters chiropractic as a form of health and wellness care, to promote the natural mechanisms for self-healing and empowerment.

I have read and understand the above statement, accept the risk, and hereby consent to chiropractic care.

Name of Child (please print)

Patient/Guardian Signature

Effective Date