CONFIDENTIAL PATIENT INFORMATION (INFANT)

*Dear Parent, **Please read and complete this questionnaire in detail**. Your answers will help us determine if chiropractic can assist your child. If we do not seriously believe your condition will respond satisfactorily, we will not accept his/her case.*

Childs Name: First _____MI _____Last _____Age: _____
Address: _____City: _____State: _____Zip: _____
Parent (s)/Guardian(s): _____
Home Phone: _____ Work Phone: _____ DOB: _____
Occupation: _____ Employer: _____
Siblings Name(s) & Age(s): _____
_____
Most patients are referred to our office by a caring family member or friend. Who may we thank for referring you to our office? _____

Insurance Information
If you are insured and wish for us to assist you in submitting your claims, please provide us with your driver's license and insurance card so that we may make a copy and verify your coverage in this office.

ADDRESSING THE ISSUES THAT BROUGHT YOUR INFANT TO THE OFFICE

Briefly describe the chief area of complaint, including the effect it has had on your child's life. _____
_____
_____
Since the problem started, is it … About the same Getting better Getting worse
What makes it worse? _____
Yes, it interferes with: Sleep Play Crawling Nursing
Does he/she suffer from any condition other than that which you are now consulting us? Yes / No Please explain._____
_____
When did this problem first appear? _____Has he/she experienced this in the past? Yes / No
Doctors seen for this problem: Chiropractor(s) _____ Medical Doctor(s) _____
Describe any treatment(s) received for this problem so far: _____
_____
Has anyone in your family experienced similar problems? Y / N If so, who? _____

When did your child first respond to sound _____ respond to Visual Stimuli _____
Cross Crawl _____ Sit Up _____ Stand alone _____ Hold head up _____
Prescription medications may cause various side effects, hide the severity of health conditions and or hinder the body's ability to heal. What medications is your infant currently taking? _____
_____
Number of doses of Antibiotics your infant has taken: During the past six months: _____, during his/her lifetime: _____
Number of doses of Other Prescription Medications your child has taken: During past six months: _____, during his/her lifetime: _____ List: _____

BODY SIGNALS

Please circle **ALL** symptoms (body signals) your child has ever had, even if they do not seem related to the current problem.

Colic	Irritability	Sleeping problems	Diarrhea
Constipation	Fever	Allergies	Colds
Ear Infections	Bronchitis	Other: _____	

Patient's/Guardian's Signature: X _____Date: _____

Family History and Personal History Information

FAMILY HISTORY (If your mom had it put an M, if dad put a D, and if both had it put a B.)

( ) High Blood Pressure ( ) Heart Attack ( ) Emphysema ( ) Asthma ( )Ulcer / Digestive Issues
( ) Diabetes ( ) Kidney Disease ( ) Mental Illness ( ) Cancer
( ) HIV Positive ( ) Thyroid Disease ( ) Circulation Problem
( ) Arthritis /Rheumatoid ( ) Seizures/Convulsions ( ) Stroke (Indicate Age at first stroke Mother ___ Father ___)

ACTIVITIES OF DAILY LIVING

Check each of the activities which you have difficulty performing or causes pain when performing.

General

___ Walking ___ Standing ___ Running ___ Sitting
___ Lifting Children ___ Bending ___ Climbing Stairs ___ Reading
___ Laying in Bed ___ Chewing ___ Swimming ___ Getting in/out of Car
___ Playing Piano ___ Using Computer ___ Kneeling ___ Sexual Intercourse
___ Sports (List:_____) ___ Sleeping ___ Using Telephone ___ Other_____

House and Yard Work

___ Laundry ___ Making Beds ___ Vacuuming ___ Doing Dishes
___ Cooking ___ Carrying Groceries ___ Caring for Pets ___ Shoveling Snow
___ Mowing Lawn ___ Raking Leaves ___ Gardening ___ Other_____

Personal Grooming

___ Combing Hair ___ Shaving ___ In/Out Bathtub ___ Brush Teeth
___ Dressing Yourself ___ Other: _____

Travel

___ Driving ___Riding (Passenger) Minutes per Day spent in ____Car ___ Bus or Other:_____

REVIEW OF SYSTEMS (Check ones that you have now or have had in the past.)

Now	Past		Now	Past		Now	Past	
___	___	Seizures	___	___	Vertigo	___	___	Dizziness
___	___	Hand Trembling	___	___	Loss of Sensation	___	___	Incoordination
___	___	Loss of Facial Expression	___	___	Weak Grip	___	___	Paralysis
___	___	Difficulty w/Speech	___	___	Tingling	___	___	Loss of Memory
___	___	Numbness	___	___	Weight Gain	___	___	Weight Loss
___	___	Breast Changes	___	___	Heat Intolerance	___	___	Cold Intolerance
___	___	Hyperventilation	___	___	Insecurity	___	___	Depression
___	___	Troubled Sleep	___	___	Irritable	___	___	Undecidedness
___	___	Timid	___	___	Hallucinations	___	___	Loss of Memory
___	___	Drug Dependency	___	___	Drug Addiction	___	___	Alcoholism
___	___	Suicidal Thoughts	___	___	Extreme Worry	___	___	Sexual Problems
___	___	Muscle Pain	___	___	Muscle Weakness	___	___	Muscle Cramps
___	___	Muscle Twitching	___	___	Joint Stiffness	___	___	Joint Pain

PAST MEDICAL HISTORY (Check ones that you have had in the past.)

___ Hay Fever	___ Mumps	___ Rheumatic Fever	___ Allergies	___ Sexual Problems
___ Cancer	___ Tumor	___ Blood Disease	___ Leukemia	___ Heart Trouble
___ Depression	___ Phlebitis	___ Hypertension	___ Stroke	___ Mental Illness
___ Jaundice	___ Polio	___ Skin Trouble	___ Gallstones	___ Liver Trouble
___ Hepatitis	___ Parasites	___ Epilepsy	___ Paralysis	___ Prostate Problem
___ Alcoholism	___ Dysentery	___ Varicose Veins	___ Diabetes	___ Gout
___ Syphilis	___ Migraine	___ Hemorrhoids	___ Nervous Breakdown	___ Gonorrhea
___ Ulcers	___ Angina	___ Bladder Trouble	___ Kidney Stones	___ Kidney Infections
___ Other_____				

IMMUNIZATIONS (Check ones that you have had in the past.)

___ DPT	___ Mumps	___ Smallpox	___ Typhoid	___ Tetanus	___ Chicken Pox
___ HPV	___ Influenza	___ Polio	___ MMR	___ HPV	___ Pneumococcal
___ Measles	___ Other_____				

Print Name:_____ Date:_____

Signature:_____