Precision Spine Care LLC

NAME: _____

Parent's ADDRESS: CITY: STATE: ZIP: _____

PARENTS PHONE (For TEXT MESSAGES): _____

Parent's Email address:_____

MALE: ____ FEMALE: _____ Birth info: LENGTH: _____WEIGHT: _____BIRTHDATE: _____

Mainly for Moms:

Did you carry to full term? _____Describe any complications and when they occurred: _____

_____

2. Tell us about your delivery and birth of this child:Midwife? _____ Hospital? _____ Obstetrician? _____

Did you have a C-Section? _____ Vacuum Extraction? _____ Did you have an Epidural? _____

What was the baby's APGAR Score? _____ Were forceps used? _____ Were you induced? _____

3. As a baby/toddler, (birth to 4 years), did any of the following occur? If more than once how many times?

____ Fall from a changing table
_____Tumble down stairs
____ Fall out of crib
____ Involved in car accident
____ Fall off playground equipment
_____Play in Jolly Jumper
____ Frequent ear infections
_____Tonsilitis
____Reaction to vaccination

____ Frequent crying spells
____ Frequent fevers
____ Frequent bouts of diarrhea
____ Constipation
____ Sleeping problems
____ Frequent colds
____ Colic
____ Did not gain weight as expected
____ Other _____

Explain the above:_____

_____

_____

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

____ Fall from a tree
____ Fall off a bicycle
____ Fall off of playground equipment
____ Involved in car accident
____ Sports Accident
____ Stomach Pains
____ Headaches
____ Scoliosis
____Depression

____ Bed wetting
____ Hyperactivity/Autism
____ Learning difficulties
____ Asthma
____ Allergies
____ Leg/knee pains
____ Anxiety
____ Other _____

Please explain the above:_____

5. Tell us about any vaccinations your child has had: _____

_____

Were there any reactions to any of these?_____

_____

6. As a child or adolescent, has your child experienced any of the following:

____ Fall from a tree
____ Fall off a bicycle
____ Fall off of playground equipment
____ Involved in car accident
____ Sports Accident
____ Stomach Pains
____ Headaches
____ Scoliosis
____Depression

____ Bed wetting
____ Hyperactivity/Autism
____ Learning difficulties
____ Asthma
____ Allergies
____ Leg/knee pains
____ Anxiety
____ Other _____

Please explain the above:_____

_____

_____

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

_____

Is this problem: Constant ____, Intermittent ____, Occasional _____, Cyclic _____? How long has it persisted? _____

When it is at its worst, how does it make your child feel? _____

_____

What have you done about it that has NOT worked? _____

_____

What makes it worse?_____

_____

What effect does this problem have on your child's body functions? _____

_____

On his/her participation in daily activities? _____

_____

7. Current Medications, and Approximately how many times have antibiotics been prescribed and taken by your child? For what conditions and durations? _____

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary for my minor child. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature:_____Date:_____
Name of parent or guardian:_____

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