

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: _____