chiropractic
HOUSE OF VITALITY

CHILD'S NAME: _____

DATE: _____ BIRTH DATE: _____

PARENT NAME: _____

ADDRESS | CITY | STATE | ZIP: PHONE: _____

CURRENT WEIGHT: _____ EMAIL: _____ NUMBER OF SIBLINGS: _____

_____ CURRENT HEIGHT: _____

Please answer the following questions to the best of your ability

Any fertility issues? ◯ Yes ◯ No If yes, Please explain: _____

Did mother smoke? ◯ Yes ◯ No

Did mother drink? ◯ Yes ◯ No

Did mother exercise? ◯ Yes ◯ No If yes, please explain: _____

Was mother ill while carrying? ◯ Yes ◯ No If yes, please explain: _____

Any Ultrasounds? ◯ Yes ◯ No If yes, please explain: _____

Please explain any notable episodes of mental or physical stress during pregnancy: _____

_____

Please explain any other concerns or notable remarks about your child's conception or pregnancy: _____

_____

Child's birth was: ◯ Vaginal Delivery ◯ Scheduled C-section ◯ Emergency C-section

At how many weeks was your child's birth? _____

Obstetrician/Midwife's name: _____

Please circle any applicable interventions or complications:

Breech Induction Pain Medications Epidural Episiotomy Vacuum Extraction Forceps Other: _____

Please describe any other concerns or notable remarks about your child's labor and/ or delivery: _____

_____

Child's birth weight: _____ Child's birth height: _____ APGAR score: _____

GROWTH & DEVELOPMENT

Is/was your child breastfed? ◯ Yes ◯ No If yes, how long? _____

Difficulty with breastfeeding? ◯ Yes ◯ No

Did they ever use formula? ◯ Yes ◯ No If yes, at what age? _____ If yes, what type? _____

Did/does your child ever suffer from colic, reflux, or constipation as an infant? ◯ Yes ◯ No If yes, please explain: _____

_____

_____

Please list your child's hospitalization and surgical history, including the year: _____

_____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year: _____

_____

Have you chosen to vaccinate your child? ◯ No ◯ Yes on an alternate schedule Yes, on schedule If yes, please list any vaccination reactions: _____

Has your child received any antibiotics or other prescription medication? ◯ Yes ◯ No If yes, how many times and list reason: _____

_____

Night terrors or difficulty sleeping? ◯ yes ◯ No if yes, please explain: _____

_____

Behavioral, social or emotional issues? ◯ Yes ◯ No if yes, please explain: _____

Yes _____

How many hours per day does your child typically spend watching a TV, computer, tablet or phone? _____

How would you describe your child's diet? ◯ Mostly whole, organic foods ◯ Pretty average ◯ High amount of processed foods ◯

REASON FOR SEEKING CHIROPRACTIC CARE: _____

_____

_____

AUTHORIZATION FOR CARE OF MINOR: I hereby authorize Chiropractic House of Vitality and doctor(s) to administer care, as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian)

SIGNED: _____ **DATE:** _____

How did you hear about Dr. Kate _____