CAROLINA FAMILY CHIROPRACTIC LLC

keeping the backbone of your family healthy

Confidential Patient Information

Child's Name:	Parent/Guardian's Name:
Street Address:	City, State, Zip:
Cell phone: Work Phone:	Home Phone:
Email: Birthdate: Age:	Child's SS#:
How did you hear about us? Weight: Height:	
Who is your primary care physician?	
Is your child receiving care from any other health professional? ◯ Yes ◯ No -If Yes, Please name them, and their specialty:	
Please list any drugs/medications/vitamins/herbs/other that your child is taking:	

Current Health Conditions

What health condition(s) bring your child to be evaluated today?	
When did this condition first begin?	How did the problem start?
Has your child ever received care for this condition before? ◯ Yes ◯ No If Yes, Please explain:	
Is this condition: ◯ Getting Worse ◯ Improving ◯ Intermittent ◯ Constant ◯ Unsure	
What makes the problem better?	What makes the problem worse?

Health Goals for Your Child

What are your top three health goals for your child:

1._____

2._____

3._____

What would you like to gain from chiropractic care?

◯ Resolve existing condition

◯ Overall Wellness

◯ Both

Have you ever visited a chiropractor? ◯ Yes ◯ No If yes, what is their name?

What is their specialty? ◯ Pain Relief ◯ Physical Therapy & Rehab ◯ Nutritional ◯ Subluxation-based ◯ Other:_____

Pregnancy & Fertility History

Please tell us about your pregnancy:

Any fertility issues? ◯ Yes ◯ No If Yes, Please explain:
Did mother smoke? ◯ Yes ◯ No If yes, how many per week?
Did mother drink? ◯ Yes ◯ No If yes, how many per week?
Did mother exercise? ◯ Yes ◯ No If yes, Please explain:
Was mother ill? ◯ 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 your pregnancy:

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

Labor & Delivery History

Child's Birth was: ◯ Natural Vaginal Birth ◯ Scheduled C-Section ◯ Emergency C-Section
At how many weeks was your child born?

Child's Birth was: ◯ At home ◯ At a birthing center ◯ At a Hospital ◯ Other:
Doctor/Obstetrician's name:

Please check any applicable interventions or complications:
◯ Breech ◯ Induction ◯ Pain Meds ◯ 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: APGAR score after 5 minutes:

Growth & Development History

Is/Was your child breastfed? ◯ Yes ◯ No If Yes, How long? Difficulty 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:

Did/Does your child frequently arch their neck/back, feel stiff, or bang their head? ◯ Yes ◯ No
If Yes, please explain:

At what age did the child:
Respond to sound: Follow an object: Hold their head up: Vocalize: Teeth:
Sit alone: Crawl: Walk: Begin cow's milk: Begin Solid foods:

Any food intolerances or allergies? If yes, when did they begin?

Any hospitalizations? Surgeries? (please include the year)

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

Please list any hospitalizations and/or major surgeries your child has received, please include the year:

Please list any major injuries, accidents, falls, and/or fractures that your child has sustained, please include the year:

Have you chosen to vaccinate your child: ◯ No ◯ Yes, on a delayed or selective schedule ◯ Yes, on schedule
Please list any vaccination reactions:

Has your child received any antibiotics: ◯ 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:

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 amounts of processed foods

ACKNOWLEDGEMENT & CONSENT

I hereby authorize Dr. Ekstam to examine me, including x-rays if indicated by my exam, and to release records to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my chiropractic records to be held in strict secret confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payment, or make payment directly to me.

By signing your name below, you certify the accuracy of your medical and/or accident history and further certify that you present to Carolina Family Chiropractic for evaluation and treatment of a health related condition and for no other purpose.

Parent/Guardian Signature: _____ **Date:** _____