## *NAUGATUCK FAMILY CHIROPRACTIC*LLC
### *Confidential PEDIATRIC Registration & Health Profile*

Date _____/_____/_____ Whom may we thank for referring you? ________________________________

Name _____________________________________________ Birthdate ____________________________

Address ___________________________________________ City ________________________________

State ________ Zip Code _____________ Age _________ Sex: _____ Height ______ Weight ________

Names of Parents / Guardians: _________________________________________________________________

Home Phone (______) ___________________ Cell phone (______) ___________________

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### *PRESENT HEALTH STATUS & GOALS*

1. What is your **PRIMARY** reason for your visit today? ________________________________________________

2. When did this begin? _______________________ 3. Symptoms appeared: ____ Gradually ____ Suddenly

4. Have you seen any doctors for this condition? _____ Y _____ N Whom? ______________________________

5. Other Health problems / Concerns? ____________________________________________________________

6. Who is your child's pediatrician? _____________________________ City / State ______________________

7. Please check any of the following that your child has suffered from (past or present), **even if they do not seem related** to the current condition:

___ Headaches ___ Neck pain/ stiffness ___ Ear Infections ___ Sinus/ Allergies
___ Chronic Colds ___ Ear Infections ___ Back pain/ stiffness ___ Scoliosis
___ Asthma Symptoms ___ Digestive Problems ___ Colic ___ ADHD
___ Sleep problems ___ Bedwetting ___ Recurring Fevers ___ Car Accident
___ Other: ______________________________________________________________________________

______________________________________________________________________________________

8. Has your family seen a Doctor of Chiropractic? ___ Y ___ N Dr's Name: ___________________________

9. **Medication**: Please list all medications your child is taking, reason for taking and prescribing doctor.

Name: ________________________ Reason: _________________________ Dr. ____________________
Name: ________________________ Reason: _________________________ Dr. ____________________
Name: ________________________ Reason: _________________________ Dr. ____________________

______ He /She is **NOT CURRENTLY** taking any medications.

10. **Vitamins / Natural Remedies**: Please list all natural supplements your child is taking.

Name: ________________________ Reason: _________________________
Name: ________________________ Reason: _________________________
Name: ________________________ Reason: _________________________

11. **Vaccination** History: ________________________________________________________________

12. Number of doses of **antibiotics** your child has taken: During the past 6 months? _______ Lifetime? _______

13. Please list any **prior surgeries** your child has had?

Type: ______________________________ Date: ______________________
Type: ______________________________ Date: ______________________
Type: ______________________________ Date: ______________________

14. **Pre-Natal & Birth History**

Any complications during pregnancy? ______________________________

Mother medications during pregnancy? ______________________________

Cigarette / Alcohol during pregnancy? ______________________________

Location of Birth ____________________ Birth weight _______ lbs. Length ________ inches

Vaginal Birth ______ C-section _______

15. **Feeding History**

Was child breast fed: ______ Y ______ N Length: ________________

Was child formula fed: ______ Y ______ N Length: ________________

Does child have any known food allergies / sensitivities (digestive upset, reactions, etc) _____ Y _____ N

List: ______________________________________________

16. **Developmental History**

Has your child been involved in any motor vehicle accidents or falls (changing table, stairs, etc)? ____ Y ____ N

List: ______________________________________________

Has your child been involved in any sports accidents, bike accidents or additional injuries? ____ Y ____ N

List: ______________________________________________

17. Has your child had any **Childhood Diseases**:

_____ Chicken Pox Age: _____
_____ Rubella Age: _____
_____ Measles Age: _____
____ Mumps Age: _____
____ Whooping Cough Age: _____
____ Other Age: _____

18. Please list or describe **anything else** you would like the Doctor to know about your child health history:

______________________________________________

______________________________________________

I certify that the above information is correct to the best of my knowledge. If at any point, any of the previous information changes, I shall notify this office immediately with the correct information. I furthermore give full consent for my child to receive a Chiropractic evaluation and care including, but not limited to spinal adjustments and x-rays if necessary.

**PARENT SIGNATURE**:______________________________ **DATE** ____/_____/_____