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WWW.GETWELLNJ.COM

(732) 617-9355

PATIENT INFORMATION

Child's Name _____ Parent(s)/Guardian(s) Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Is it okay to contact you at work? ☐ Yes ☐ No

E-mail _____ Child's Social Security # _____ Birthdate _____ Age _____

Have you or your child ever had chiropractic care before? ☐ Yes ☐ No

If yes, please tell us the doctor's name _____

Were you pleased with your care? ☐ Yes ☐ No

How did you find out about our office? _____

Is this appointment related to an auto accident? ☐ Yes ☐ No

If this injury is related to an auto accident, please fill out the Auto Accident Questionnaire.

Is your child receiving care from other health professionals? ☐ Yes ☐ No

If yes, please name them and their specialty _____

Who is your family's primary care physician? _____

Please list any drugs or medications your child is taking _____

Please list any vitamins/herbs/homeopathics/other your child is taking _____

Please list any allergies your child has _____

CURRENT HEALTH

What health condition brings your child to our office? _____

When did the symptoms first begin? _____

How did the problem start? ☐ Suddenly ☐ Gradually ☐ Post-Injury

Is this condition ☐ Getting Worse ☐ Improving ☐ Intermittent ☐ Constant ☐ Not Sure

What makes the problem better? _____

What makes the problem worse? _____

Has your child ever had a similar condition? ☐ Yes ☐ No

Please explain _____

Has your child been treated for this problem before? ☐ Yes ☐ No

Please explain _____

Does your child eat well? ☐ Yes ☐ No

Does your child have regular bowel/bladder movements? ☐ Yes ☐ No

Has your child ever been checked for vertebral subluxations? ☐ Yes ☐ No ☐ Don't Know

Child's birth was ☐ At home ☐ At a birthing center ☐ At a hospital

My obstetrician/midwife/family physician was _____

Child's birth was ☐ Natural vaginal (no medications/interventions)

☐ Vaginal with interventions

☐ Induction ☐ Pain medication ☐ Epidural ☐ Episiotomy ☐ Vacuum extraction ☐ Forceps

☐ Other _____

☐ C-section

☐ Scheduled ☐ Emergency

Please list reasons for any interventions/complications _____

Child's birth weight _____ Child's birth height _____ Current weight _____ Current height _____

APGAR score at birth _____ APGAR score after 5 minutes _____

Was your child alert and responsive within 12 hours of delivery? ☐ Yes ☐ No

If no, please explain _____

At what age did the child:

Respond to sound _____ Follow an object _____ Hold head up _____ Vocalize _____

Sit alone _____ Teethe _____ Crawl _____ Walk _____

Patient/Hospitalization/Surgical history (please list below all surgeries and hospitalizations, including the year)

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

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

Formula introduced at age _____ What type? _____

Introduction of cow's milk at age _____ Began solid foods at age _____

Please list any foods/juice intolerance _____

Did mother smoke during pregnancy? ☐ Yes ☐ No

Did mother drink alcohol during pregnancy? ☐ Yes ☐ No

Any illness of mother during pregnancy? ☐ Yes ☐ No

If yes, please explain including treatment/medications/supplements _____

List any drugs/medications (including over the counter) taken during pregnancy _____

List any supplements taken during pregnancy _____

Any exposures to ultrasound? ☐ Yes ☐ No If so, how many and what was the medical reason? _____

Any pets at home? ☐ Yes ☐ No Any smokers at home? ☐ Yes ☐ No

Has child received any vaccinations? ☐ Yes ☐ No

If yes, which ones and list any reactions _____

Has child received any antibiotics? ☐ Yes ☐ No If yes, how many times and list reason _____

Any difficulty with breastfeeding? ☐ Yes ☐ No If yes, please explain _____

Any difficulty with bonding? ☐ Yes ☐ No If yes, please explain _____

Any behavioral problems? ☐ Yes ☐ No If yes, please explain _____

Any night terrors, sleepwalking or difficulty sleeping? ☐ Yes ☐ No If yes, please explain _____

Age child began daycare _____ Average number of hours of TV per week _____

Does your child seem normal for their age? ☐ Yes ☐ No If no, please explain _____

Check those involving immediate family and add identification: M=Mother; F=Father; S=Siblings; G=Grandparents

☐ Cancer, type _____
☐ M ☐ F ☐ S ☐ G

☐ Depression
☐ M ☐ F ☐ S ☐ G

☐ Diabetes
☐ M ☐ F ☐ S ☐ G

☐ Back Problems
☐ M ☐ F ☐ S ☐ G

☐ Heart Disease
☐ M ☐ F ☐ S ☐ G

☐ Liver Disease
☐ M ☐ F ☐ S ☐ G

☐ High Blood Pressure
☐ M ☐ F ☐ S ☐ G

☐ High Cholesterol
☐ M ☐ F ☐ S ☐ G

☐ Lung Problems
☐ M ☐ F ☐ S ☐ G

☐ Scoliosis
☐ M ☐ F ☐ S ☐ G

☐ Neck Problems
☐ M ☐ F ☐ S ☐ G

☐ Osteoporosis
☐ M ☐ F ☐ S ☐ G

☐ Seizures
☐ M ☐ F ☐ S ☐ G

☐ Osteoarthritis
☐ M ☐ F ☐ S ☐ G

☐ Rheumatoid Arthritis
☐ M ☐ F ☐ S ☐ G

☐ Other _____

Do you know what a subluxation is? ☐ Yes ☐ No

Do any of your friends or relatives see a chiropractor? ☐ Yes ☐ No

If yes, do they use chiropractic for ☐ Health maintenance/optimization ☐ Health problems ☐ Both

Are you seeking chiropractic for ☐ Health maintenance/optimization ☐ Health problems ☐ Both

What would you like to gain from chiropractic care? _____

Are there other health concerns or anything else you'd like us to know about your child? _____
