



## Age 5 and younger

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|--|---|
| Name:  | Date of Birth:<br>Sex: Male Female  |
| Mailing Address:                                   | Parent/Guardian Names & Phone Numbers:  |
| E-Mail:  | Family Medical Doctor:  |
| Name and ages of other children:                   | Referred by: please list person's name<br><input type="radio"/> Friend/Family <input type="radio"/> M.D. / D.C.<br><input type="radio"/> Internet/Add |
| Chiropractic care before? If so, when and by whom? |   |

Castle Hills Chiropractic focuses on your child's ability to be healthy. Our goals are to first address the issues that brought you and your child to our office and second, offer the opportunity to improve your child's health potential in the future. Life activities include events that cause damage and this damage builds layer upon layer even to levels at which you may not yet be aware.

Research is showing that many of the health challenges that occur later in life have their origins during the developing years, some starting at or before birth. We need to know what your child's layers of damage contain, so we ask you to carefully and completely fill out this important form.

**Labor and Delivery**

- Hospital with doctor       Hospital with midwife       Home with midwife  
 Breach       Caesarian       Fetal monitor used  
 Medications       Forceps       Length of delivery: \_\_\_\_\_  
 Describe any complications: \_\_\_\_\_

Name of midwife: \_\_\_\_\_

**Prenatal & Infant History**

Number of ultrasounds during pregnancy: \_\_\_\_\_      Duration of pregnancy in weeks: \_\_\_\_\_

APGAR score at birth: \_\_\_\_\_      Birth length: \_\_\_\_\_      Birth Weight: \_\_\_\_\_

**Please check any problems your child had at birth**

Jaundice     Cyanosis     Choking     Other: \_\_\_\_\_

**Please check if any of the following applied to your child after birth up to today**

Medication     Artificial feeding     Vitamin K     Surgery     Erythromycin     Circumcision  
 Other: \_\_\_\_\_

**Nutrition**

Solid food     Breast milk     Cow's milk     Goat's milk     Soy milk     Rice milk  
 Fruit juice     Sweets     Vitamins     Medication     Commercial formula  
 Other: \_\_\_\_\_

**Please list any medication taken – prescription and over the counter:** \_\_\_\_\_

**Developmental History**

If younger than two, please indicate which of the following milestones your child has reached:

Hold head up     Sits up     Crawls     Stands unaided     Walks unaided

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (ie, bed, changing table, down the stairs) was this case with your child?  Yes  No

If yes, please describe the circumstances: \_\_\_\_\_

Has your child ever been involved in a high impact/contact type of sport?  Yes  No Please list: \_\_\_\_\_

Has your child ever been treated on an emergency basis?  Yes  No Please describe: \_\_\_\_\_

Describe other injuries or falls not listed above: \_\_\_\_\_

List any prior surgeries: \_\_\_\_\_

Is your child vaccinated?  Yes  No Describe any reactions: \_\_\_\_\_

**Has your child had any of the following illnesses? Indicate age**

Measles (Rubeola) \_\_\_\_\_     Mumps \_\_\_\_\_     Rubella (German measles) \_\_\_\_\_     Chicken pox \_\_\_\_\_  
 Pertussis (Whooping cough) \_\_\_\_\_     Other \_\_\_\_\_

Chiropractic has helped children with many health problems like asthma, allergies, bed-wetting, colic, ear infections (acute and chronic), headaches, scoliosis, etc. Chiropractic care has also been shown to help prevent these and other illnesses from occurring and ensure children have a healthier life. To optimally prevent these, a child should have a chiropractic spinal exam as soon as they are born.

**What is your goal or expectation with chiropractic care?** \_\_\_\_\_

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I hereby authorize the doctor to examine and treat my child as deemed appropriate through the use of chiropractic care and I give authority for these procedures to be performed. I have been informed of the financial policy and agree that I am responsible for all expenses incurred at Castle Hills Chiropractic. I have had an opportunity to review the privacy policy and agree to its terms.

Your child's name (printed): \_\_\_\_\_

Parent/Guardian Name (printed): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_