

CONFIDENTIAL PATIENT INFORMATION

Child's Name:

Date of Birth:

Gender:

Parent/Guardian Name(s):

Child's Social Security #:

Street Address:

Apt./Unit #:

City:

State:

Zip Code:

Cell Phone:

Home Phone:

Work Phone:

Email:

Height:

Weight:

Mother's Name:

Mother's Date of Birth:

Mother's Cell Phone:

Father's Name:

Father's Date of Birth:

Father's Cell Phone:

Who is responsible for payment:

Responsible Payor's Social Security #:

Who is the child's primary care physician?

How did you hear about us? (please select all that apply & list who)

☐ Current Patient (list who)☐ Professional Referral/Doctor (list who)☐ Google Search☐ Community Partner (list who)☐ Social Media (which platforms)☐ Other (specify)Is your child receiving care from any other health professionals? ☐ Yes ☐ No

If yes, please name them and their specialty:

	Name	Specialty
1		
2		
3		

Please list any drugs/medications/vitamins/herbs/other that your child is taking

	Name	Specialty
1		
2		
3		
4		





CURRENT HEALTH CONDITIONS

1. What are the primary health concerns for your child?

2. Please describe when your child's issues began and how they've progressed since:

3. What makes things better?

4. What makes things worse?

HEALTH GOALS FOR YOUR CHILD

1. What are your top three health goals for your child?

2. What would you like to gain from chiropractic care:

☐ Resolve existing condition ☐ Overall wellness + prevention ☐ Both

3. 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.

1. Any fertility challenges? ☐ Yes ☐ No

If yes, please explain:

2. Did mother smoke? ☐ Yes ☐ No

3. Did mother drink? ☐ Yes ☐ No

4. Did mother exercise? ☐ Yes ☐ No

If yes, please explain:

5. Was mother ill? ☐ Yes ☐ No

If yes, please explain:

6. Any ultrasounds? ☐ Yes ☐ No

If yes, please explain:

7. Please explain any notable episodes of emotional or physical stress during mother's pregnancy:

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

LABOR & DELIVERY HISTORY

1. Child's birth was: ☐ Vaginal Birth ☐ Scheduled C-Section ☐ Emergency C-Section

At how many week's was your child born?

2. Child's birth was: ☐ At home ☐ At a birthing center ☐ At a hospital ☐ other

3. Birth Provider's Name:

4. Please check any applicable interventions or complications:

☐ Breech ☐ Induction ☐ Pain Meds ☐ Epidural ☐ Episiotomy

☐ Forceps ☐ Manual assistance ☐ Vacuum extraction ☐ Cord-wrapped ☐ None

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

6. Child's birth weight: Child's birth height: APGAR score at birth: APGAR score at 5 minutes:

GROWTH & DEVELOPMENT HISTORY

1. Is/was your child breastfed? ☐ Yes ☐ No

If yes, how long

2. Difficulty with breastfeeding? ☐ Yes ☐ No

If yes, is/was there a certain side that is/was more difficult for them

3. Did they ever use formula? ☐ Yes ☐ No

If yes, at what

4. Did/does your child ever suffer from colic, reflux, skin issues, or constipation as an infant?

☐ Yes ☐ No

If yes, please explain:

5. Did/does your child frequently arch their neck/back, feel stiff, or bang their head?

☐ Yes ☐ No

If yes, please explain:

6. At what age did the child:

	Age
Respond to sound	
Follow an object	
Hold their head up	
Vocalize	
Teething	
Sit alone	
Crawl	
Walk	
Begin cow's milk	
Begin solid foods	

7. Please list any food intolerance or allergies, and when they began:

	Food intolerance/Allergy	When they began
1		
2		
3		

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

	Hospitalization/Surgery	Year
1		
2		
3		
4		

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

	Hospitalization/Surgery	Year
1		
2		
3		

10. Have you chosen to vaccinate your child?

☐ No ☐ Yes, on a delayed or selective schedule ☐ Yes, on schedule

11. Has your child received any antibiotics?

☐ Yes ☐ No

12. Any difficulty with bonding or social development?

☐ Yes ☐ No

13. Night terrors or difficulty sleeping?

☐ Yes ☐ No

14. Behavioral, social or emotional issues?

☐ Yes ☐ No

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

16. How would you describe your child's diet?

☐ Mostly whole, organic foods ☐ Pretty average ☐ High amount of processed foods

17. Are there other health concerns, or is there anything else you'd like us to know about your child?

PATIENT REVIEW OF SYSTEMS

The nervous system controls and coordinates all organs and structures of the human body.

Please check the corresponding boxes for each symptom or condition you have experienced—including both past and present.

	Past	Present
Colic & Excessive Crying	☐	☐
Difficulty Latching / Nursing	☐	☐
Reflux & Excessive Spit Up	☐	☐
Projectile Vomiting	☐	☐
Frequent Stiffening, Rigidity, Arching	☐	☐
Difficulty Sleeping	☐	☐
Torticollis	☐	☐
Plagiocephaly	☐	☐
Motor Milestone Delays	☐	☐
Low Tone & Coordination Challenges	☐	☐
Speech & Communication Delays	☐	☐
Sensory Processing Challenges	☐	☐
Frequent Tantrums & Meltdowns	☐	☐
Behavior Issues	☐	☐
Hyperactivity & Impulsivity	☐	☐
ADHD / ADD	☐	☐
Balance & Coordination Issues	☐	☐
Visual & Auditory Processing Challenges	☐	☐
Handwriting & Fine Motor Challenges	☐	☐
Low Energy & Fatigue	☐	☐
Depression & Lack of Confidence	☐	☐
Lightheadedness & Dizziness	☐	☐
Frequent Nausea & Malaise	☐	☐
Headaches & Migraines	☐	☐
Stiff Neck & Shoulders	☐	☐
Jaw, Swallowing, Sensory Food Aversions	☐	☐
Vision & Hearing Issues	☐	☐
Ear & Sinus Infections	☐	☐
Sore Throat & Strep	☐	☐
Swollen Tonsils & Adenoids	☐	☐
Strep & Upper Respiratory Infections	☐	☐
Allergies & Autoimmune Challenges	☐	☐

PATIENT REVIEW OF SYSTEMS (cont.)

	Past	Present
Social / Emotional Challenges	☐	☐
Anxiety & Emotional Instability	☐	☐
Chronic Inflammation	☐	☐
Poor Metabolism & Weight Control	☐	☐
Chronic Chest Colds & Cough	☐	☐
Bronchitis & Pneumonia	☐	☐
Asthma	☐	☐
Blood Sugar Problems	☐	☐
Skin Conditions / Rash	☐	☐
Ulcerative Colitis, Crohn's, IBS	☐	☐
Kidney Challenges	☐	☐
Gas Pain & Bloating	☐	☐
Gluten & Casein Intolerance	☐	☐
Constipation	☐	☐
Bladder & Urination Issues	☐	☐
Hormonal Challenges	☐	☐
Low Back Pain & Stiffness	☐	☐
Lumbopelvic / SI Joint Pain	☐	☐
Tight Hamstrings & Calves	☐	☐
Toe Walking	☐	☐
Poor Circulation & Cold Feet	☐	☐
Weak Ankles & Arches	☐	☐

INFORMED CONSENT

I understand that I am directly and fully responsible to Full Potential Chiropractic, PC for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

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Parent or Legal Guardian Signature	Date	Doctor's Signature	Date