Healthy for Life Chiropractic
Pediatric Entrance Form
Dr. Cara Davis

CHILD'S NAME _____ DATE _____

BIRTHDATE _____ MALE _____ FEMALE _____

PARENT'S NAMES _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ WORK/CELL # _____

NAME OF PERSON(S) WHO REFERRED YOU _____

NAMES AND AGES OF SIBLINGS LIVING AT HOME _____

WHAT IS THE MAIN REASON YOU ARE SEEKING CHIROPRACTIC CARE? PLEASE ELABORATE (**IF THIS APPOINTMENT IS FOR WELLNESS CHECK UP PLEASE SKIP TO THE TOP OF THE NEXT PAGE)**

WHEN DID YOU **FIRST** NOTICE THE PROBLEM? _____

HAS YOUR CHILD HAD THIS PROBLEM MORE THAN ONCE? YES ___ NO ____
HOW MANY TIMES? _____

HAVE YOU TRIED ANYTHING ELSE TO TREAT THE PROBLEM? YES __ NO __

PLEASE LIST ANY OTHER CARE YOU HAVE RECEIVED FOR THIS PROBLEM:

PLEASE DESCRIBE HOW THIS PROBLEM AFFECTS THE REST OF THE FAMILY:
_____

PLACE OF BIRTH: HOSPITAL _____ HOME _____ BIRTHING CENTER _____

PLEASE DESCRIBE THE LABOR AND DELIVERY PROCESS OF THIS CHILD:

WERE THERE ANY COMPLICATIONS OR INTERVENTIONS (FORCEPS, SUCTION, EPIDURAL)? _____

LIST THE NUMBER OF ANTIBIOTIC DOSES IN THE LAST 6 MONTHS _____
LIST THE NUMBER OF ANTIBIOTIC DOSES IN CHILD'S LIFETIME _____

PLEASE LIST **ANY** OTHER PRESCRIPTIONS OR OVER THE COUNTER DRUGS TAKEN AND THE REASONS FOR EACH: _____

PLEASE LIST **ALL** IMMUNIZATIONS AND THE AGE OF THE CHILD AT THAT TIME:
_____

LIST **ANY** ACCIDENTS OR SIGNIFICANT FALLS (STAIRS, CHANGING TABLE, PLAYGROUND, SWINGS, SPORTS, AUTO, ETC) IN YOUR CHILD'S LIFETIME:

DOES YOUR CHILD EXPERIENCE:

___ ALLERGIES	___ POOR SLEEP HABITS	___HEADACHES
___ ASTHMA	___EAR ACHES/INFECTION	___BED WETTING
___ POOR IMMUNE FUNCTION	___SINUS PROBLEMS	___SKIN PROBLEMS
___FREQUENT COLDS	___BOWELS SLOW/FAST	
___STREP THROAT	___COORDINATION DIFFICULTIES	
___PNEUMONIA	___FOCUS/ATTENTION PROBLEMS	
___COLIC/DIGESTIVE PROBLEMS	___GROWING/BACK PAINS	___SCOLIOSIS

PLEASE LIST ANY OTHER HEALTH RELATED PROBLEM YOUR CHILD CURRENTLY HAS OR ENCOUNTERS ON AN OCCASIONAL BASIS (PLEASE THINK HARD AS THIS IS IMPORTANT): _____

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:
____ WE ARE INTERESTED IN CRISIS AND EMERGENCY CARE ONLY
____ WE ARE INTERESTED IN CARE THAT WILL HELP REGAIN OPTIMAL HEALTH AND PREVENT FUTURE BREAK DOWNS IN HEALTH

I UNDERSTAND THE INFORMATION CONTAINED WITHIN THIS FORM AND GUARANTEE THIS FORM WAS COMPLETED CORRECTLY AND TO THE BEST OF MY KNOWLEDGE.

PARENT'S SIGNATURE _____ DATE _____