Winfield Chiropractic & Rehab

Kids & Chiropractic

Pleae complete fully so we can best help your child.

Douglas A. Swanson, D.C. Brad J. Swanson, D.C.

1. PATIENT INFORMATION

date

Name Child Prefers To Be Called:

School Status:

Parents Names:

Favorite Hobbies or Interests:

2. HEALTH INFORMATION

Please select any of the applicable reasons for your pursuing chiropractic care for your child:

___ He/she is continuing care from another chiropractor.
___ I recently had my spine checked and see the value in a family subluxation check-up.
___ I talked with the doctor and he suggested that my child come in.
___ I'm concerned about his/her health and am looking for answers.
___ He/she has a specific condition that concerns me.
If so, please explain: _____
_____
___ I have no idea why we are here. (That's okay, we will take the time to explain what we do).

In order to better understand your child's current level of health, please check any of the following body signals that your child has currently or has previously had:

☐Headaches	☐Seizures	☐Autism/PDD
☐ADD/ADHD	☐Growing Pains	☐Postural Imbalances
☐Scoliosis	☐Allergies	☐Frequent Colds
☐Sinus Problems	☐Ear Infections	☐Asthma
☐Colic	☐Digestive Problems	☐Bed Wetting

☐Other_____

Do you have family members with similar health concerns? _____ If so, who? _____
Other doctors he/she has seen for this problem: _____
Surgeries or major illnesses your child has had: _____
Known Allergies: _____

Number of doses of Antibiotics your child has taken:
During the past 6 months: _____ Total during Lifetime: _____
Number of doses of other prescription medications taken:
During the past 6 months: _____ Total during Lifetime: _____
List any current medications: _____
List any past medications: _____

3. PRENATAL HISTORY

patients name

Adopted? _____

Complications during pregnancy? _____. If so, please explain: _____

_____

Medications/drugs/caffeine during pregnancy? _____. If so, please list type and amount: _____

_____

Cigarette/Alcohol use during pregnancy? _____. If so, please list type and amount: _____

_____

Ultrasounds during pregnancy? _____. If so, how many? _____

Location of birth: _____Hospital _____Birthing Center _____Home

Birth Intervention:_____Mother Induced _____Mother Medicated (Pitocin, etc.) _____C-Section

_____Forceps _____Vacuum Extracted

_____Baby given Medication after delivery; List: _____

Complications during delivery?_____. If so, please explain: _____

_____

Genetic Disorders/Disabilities? _____. If so, please explain: _____

_____

Breast Fed?_____How long?_____ Formula Fed? _____ How long? _____

Introduced to solid food at _____ months?

Cow's milk at_____ months?

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (i.e. a bed, changing table, down stairs, etc.).

Was this the case with your child?_____. Please explain: _____

_____

_____

Is/Has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, hockey, baseball, cheerleading, martial arts, etc.)?_____. If so, please list: _____

_____

_____

The above information is true and accurate to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____