FAMILY FIRST CHIROPRACTIC
and Wellness Center

Patient Introduction

(Please completely fill in all lines of form. Thank You)

Child History:

Child's Name: _____
First Middle Last

Gender: _____ Pronoun: _____

Birth Date: Month: _____ Day: _____ Year: _____

Previous Chiropractor: _____ City: _____

Last visit to this Chiropractor: _____

Reason for leaving: _____

Current Pediatrician: _____ City: _____

Parent Information:

Your Name: _____
First Middle Last

Your Address:
Street: _____

City: _____ State: _____ Zip: _____

Social Security Number _____ - _____ - _____ (This line must be filled out)

Telephone: Home: _____ Bus: _____

Cell: _____ Cell Carrier: _____
Do you want to opt in for text message appointment reminders: Y N

Email Address: _____ Date of Birth: _____

Emergency Contact: _____ Phone: _____

Referred to our Office by: _____

I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment.

Signature: _____ Date _____

FAMILY FIRST CHIROPRACTIC
and Wellness Center

Initial Child & Adolescent Questionnaire

Child's Name: _____, Parent: _____

Parent: _____

Mainly for Moms:

1. Tell us about your pregnancy;

Did you carry to full term? _____

Describe any complications and when they occurred: _____
_____
_____

2. Tell us about your delivery and birth of this child:

Did you use a midwife? _____ Hospital? _____ Obstetrician? _____

Did you have a C-Section? _____ Were forceps used? _____

Vacuum Extraction? _____ Were you induced? _____

Did you have an Epidural? _____ Was it a difficult birth? _____

What was the baby's **APGAR** Score? _____ at 5 minutes? _____

3. Tell us more:

Did you breastfeed? _____ How long? _____ What formula after?_____

Did you consume alcohol during your pregnancy? _____ How much? _____

Did you smoke? _____ How much? _____ How long? _____

Did you take any medication during your pregnancy? _____

For what? _____ What type? _____

Any exposures to Ultrasound?_____, How many?_____

4. As a baby/toddler, (birth to 4 years), did any of the following occur?

___ Fall from a change table
___ Tumble down stairs
___ Fall out of crib
___ Involved in car accident
___ Fall off playground equipment
___ Play in a Jolly Jumper
___ Frequent ear infections
___ Tonsillitis
___ Reaction to vaccination
___ Frequent crying spells
___ Frequent fevers
___ Frequent bouts of diarrhea
___ Constipation
___ Sleeping problems
___ Frequent colds
___ Colic
___ Did not gain weight
___ Other_____

Please explain the about:_____

_____

5. As a young child, (5-12 years), did any of the following occur?

___ Fall from a tree
___ Fall off a bicycle
___ Fall off playground equipment
___ Sports accident
___ Car accident
___ Stomach pains
___ Scoliosis
___ Bed wetting
___ Hyperactivity/Autism
___ Learning difficulties
___ Asthma
___ Allergies
___ Leg/knee pains
Other_____

Please explain the above:_____

_____

6. Tell us about any vaccinations your child has had: _____

_____

Any reactions to any of these?_____

Were you told that you had a choice in vaccinating your child? ___**YES** ___**NO**
Would you like information on the other side of this issue? ___**YES** ___**NO**

7. As a child or adolescent, has your child experienced any of the following:

___ Headaches
___ Dizziness
___ Ringing in ears
___ Asthma
___ Hyperactivity
___ Fatigue
___ Numbness in arms/hands
___ Arm/wrist pains
___ Sleeping problems
___ Allergies
___ Stomach problems
___ Weight gain/loss
___ Foot/ankle/knee pains
___ Tingling in arms/legs
___ Neck/back pains
___ Shoulder pains
___ Growing Pains
___ Other_____

Please explain any of the above:

_____

_____

8. Which of the problems you have checked off is the worst? _____

Is this problem: Constant _____, Intermittent _____, Occasional _____ Cyclic_____

9. How long has it persisted? _____

10. When it is at its worst. How does it make your child feel ? _____

11. What have you done about it that had NOT worked? _____

_____

_____

12. What makes it worse? _____

13. What effect does this problem have on your child's body functions? _____

_____

_____

On his/her participation in daily activities? _____

14. Describe any hospital stays : _____

_____

15. Approximately how many times have antibiotics been prescribed and for what conditions?

_____

_____

16. List any medications your child is currently taking:
Are you on any type of medication? Please list all: (use back of page for more medications)

1._____ 3._____

2._____ 4._____

17. To summarize, what is your purpose for this appointment? _____

_____

_____

18. Is there anything else you feel we should know?_____

_____

_____

_____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us help your child be at their optimal wellness: _____

Signature of parent or guardian: _____ Date: _____

Patient Birth Records Release

I, _____(Your Name), Parent (or legal guardian) of the below mentioned child, hereby authorize and direct(Hospital, Birth Center, Midwife) _____ to release the records relating to the birth of _____(Your Child's Name), to:

Family First Chiropractic & Wellness Center
746 E Winchester St. Suite G-10
Murray, UT 84107
801-281-1688
Fax 801-210-5330

Date of Birth: _____

May this signed consent form be your good authority to do so.

Patient Signature: _____ Date: _____

Witness: _____