NASHUA FAMILY CHIROPRACTIC

29 Riverside Street, Units A and B, Nashua, NH 03062 P: (603) 880-4150 F: (603) 880-6765

Mission: *"To raise the vibration of <u>everyone</u> who walks through our door."*
Vision: *"To revolutionize healthcare in our community."*

Welcome to Our Family! **Your child's health history is important to us. Please fill out this form COMPLETELY.**		
Today's Date:		
Patient First Name:	Patient Last Name:	
Parent/Guardian Name (s):		
Relationship to Patient:		
Street Address:		
City:	State:	Zip Code:
Home #:	Cell #:	Work #:
Would you like us to send you a text message for your future appointment reminders? ☐ **Yes, Text Please!** ☐**No Thank you, No Reminder needed.** **If yes, what is your Cell Phone Carrier? _____**		
Email:		
Date of Birth: / /	Age:	Sex: ☐Female ☐Male ☐Other_____
Emergency Contact Name:	Relationship:	
Emergency Contact Phone #: ( )	Secondary #: ( )	
Primary Care Provider:	Phone: ( )	
Primary Care Provider Address:		
☐ Please do not share results of this visit with this provider		
Who may we thank for referring you?		

What school/daycare does the patient attend:		
If you know your child's approximate height and weight please specify here	Height: _____'_____"	Weight: _____lbs
Why are you seeking chiropractic care? ☐Pain ☐Wellness ☐Nutrition/Lifestyle ☐Other		
What is the area of complaint?		
When did the symptoms start?		

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Has your child experienced this before?	
Is this condition due to an automobile accident?	☐ No ☐ Yes
Has your child been seen by another provider or received treatment for this condition?	☐ No ☐ Yes Whom?
Has there been any previous tests, x-rays, CT scans or MRI's previously taken?	☐No ☐ Yes What was done?
Has your child been checked by a doctor of chiropractic before?	☐ No ☐Yes Whom?

Medications/Allergies		
Current Medications: Please list all prescriptions, over-the-counter medicines and dietary supplements. If possible, include the brand name for supplements. If NO current medications please check here ☐		
Medication/Supplement	Dose	Frequency
1.		
2.		
3.		

Please list any known allergies your child may have. If no known allergies, check here ☐	
1.	2.
3.	4.

Prenatal History	
Is your child adopted?	☐No ☐Yes
Was your child conceived naturally or with assisted reproductive technology?	☐Natural ☐Assisted
Were there any complications during pregnancy or birth?	☐No ☐ Yes
Did you smoke?	☐No ☐Yes
Did you consume alcohol?	☐No ☐Yes
Were you taking any medications?	☐No ☐Yes, I took _____
Place of birth:	Provider:

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Type of birth: ☐Vaginal ☐C-section ☐Water birth
Were pain medications used? ☐No ☐Yes
Was labor induced? ☐No ☐Yes
Was your child malpositioned during birth? Breech, etc. ☐No ☐Yes
Were there any interventions? ☐Doctor/Midwife assisted ☐Twisting/pulling ☐Forceps ☐Vacuum Extraction
Did/do you breast feed your child? ☐No ☐Yes If yes, for how long?_____ Did/does your child prefer one breast over the other? ☐No ☐Yes- ☐Right ☐Left

Please check the following boxes if your child HAS or HAD any of the listed symptoms/conditions.

Cardiovascular	**Digestive**	**Endocrine**	**Integumentary**
☐Heart Defect	☐Reflux/GERD	☐Diabetic ☐Type I ☐Type II	☐Psoriasis
☐Excessive Bruising	☐Colic	☐Swollen glands	☐Eczema
☐Palpitations	☐Constipation	☐Other	☐Acne
☐Asthma	☐Diarrhea	**Developmental**	☐Rash
☐Persistent cough	☐Food Sensitivities	☐Delayed Speech	☐Birth marks
☐Mouth-breather	☐Poor Appetite	☐Delayed gross motor skills	☐Other
	☐Tongue/Lip Tie		
☐Congestion	☐Other	☐Delayed fine motor skills	
☐Bronchitis/Pneumonia		☐ Delayed social skills	
☐Other		☐ Other	
Immune	**Constitutional**	**Musculoskeletal**	**Neurological**
☐Chronic colds	☐Lethargic	☐Joint/Bone pain	☐Dizziness
☐Laryngitis/Tonsillitis	☐Difficulty sleeping/ Irregular sleep patterns	☐Growing pains	☐Balance/Coordination Issues
☐Ear & Sinus Infections			
☐Low Energy	☐Bed-wetting	☐Headaches	☐Epilepsy/Seizures
☐ UTI's	☐Pre-mature birth	☐Developmental /Motor Skill Delays	☐ Visual/hearing issues
☐Other			
	☐PTSD	☐Torticollis	☐ADD/ADHD
	☐Other	☐Scoliosis	☐Focus/Memory Issues
		☐Abnormal Walking	☐Speech Issues
		☐Poor Posture	☐Anxiety/Depression

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Daily Habits	
How much exercise does your child get?	
Does your child use a Johnny jump up, bumbo or any other sit/stand-assist?	
How much time does your child spend watching TV or a screen?	About_____ hrs. per day
What sports or activities does your child participate in?	☐My child doesn't engage in sports/activities ☐Yes, my child plays…
What position does your child sleep in? **How much sleep are they getting a day?**	☐Back ☐Side ☐Stomach _____ hrs.
What is a typical breakfast for your child?	
How would you rate their diet?	☐Poor ☐Fair ☐Healthy ☐Very Healthy

Please date/list reasons for any hospitalizations or surgical procedures.	
Date	**Reason**

Please describe any other injuries/accidents not mentioned previously.	
Date	**Injury**

Are there any past or current medical conditions you have not told us about?
Is there anything additional we should know about your child?

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Family History Please include any pertinent, *immediate* family medical histories (Diabetes, hypertension, cardiac arrest, stroke, cancer, rheumatoid arthritis etc.)	

Parent/Guardian Signature:_____ Date: _____