D'Angiolillo Chiropractic Center

Helping all ages reach their maximum health potential

Patient's Name:____ Social Security Number:_________________________

Address:____________________________ Town:_____________________________ State________ Zip:__________

Mother's Name:___________________________ Father's Name:____

Home Telephone:__________________ Mother's Work#: _____________________ Father's Work#:_________________

How Were You Referred To This Office:_______________________ E-mail Address:___________________________

Sex: M F Age:______ Birthdate:_____________ Number of Siblings:________________

Birth Weight:______________ Current Weight:_____________

Birth Length:_____________ Current Length:_____________

Reason for consulting our office____

____

Have other doctors been seen for this condition? ☐ Yes ☐ No

If Yes, The Name of the physician:_________________________________ and treatment given:_________________

FAMILY HEALTH HISTORY: Please list any chronic or acute health conditions.

Siblings:____

Parents:____

Grandparents, aunts & uncles:____

Name of previous chiropractor: and address:____

Name of pediatrician:___________________________ Are you happy? ☐ Yes ☐ No

Date of last visit:____________________________ Purpose:____

Number of doses of antibiotics: past six months:_______ during the past year:_______ lifetime:_________

List other medications taken:____

CHILDHOOD DISEASES: If contracted, insert the age in which your child contracted the illness.

Measles: Rubella (German Measles)______ Rubeola________

Chicken Pox:_______ Whooping Cough_______

Mumps:_______ Other:____

IF INOCULATED: List the type and age at which your child was inoculated

____

____

Type of Birth: Vaginal:_______ Caesarean:_______ Induced:_______
Home:________ Birthing Center_______ Hospital:_______

Name of Mid-wife or Obstetrician:____

Any problems during labor and delivery? ____

Forceps:_______ Vacuum Extraction:_______ Breech:_______

Congenital Anomalies (birth defects):____

APGAR Scores:_______/_______ At birth was there the presence of : Jaundice?_______ Cyanosis?_______

Any problems during pregnancy?____

Did you use alcohol, tobacco, prescription or non prescription drugs at any time during your pregnancy?

____

INFANT FEEDING: Breast:_______ Bottle:_______ Formula type used:_________________________

First introduction to cow's milk:_________ Cereal:_______ Solid Food:_______

Any reactions or allergies to foods?____

Does your child have a well balanced diet or does he/she eat only certain foods?__________________________

____

What vitamins does your child take?____

Number of hours sleep per night:_________ Quality of sleep: Good_______ Fair:_______ Poor:_______

Has your child ever been seen in the emergency room? Yes:_______ No:_______

For what reason?____

Has your child ever had surgery?____

The following milestones are important indicators of neurological development and a time at which your child's spine should be checked for proper development.

At what age did your child:

Respond to sound:_______ Crawl:_______

Follow an object with his/her eyes:_______ Stand:_______

Hold head up:_______ Walk alone:_______

Sit alone:_______ Speak:_______

The National Safety Council discovered that nearly 50% of children fall headfirst from a high place (changing table, bed, etc.) during their first year of life. Did your child experience such an accident?_________________

The US Consumer Product Safety Commission reports that 4 million children suffer sports related injuries that are treated in emergency rooms each year, and another 8 million are seen by their family physicians. Does your child participate in any of the following high impact sports? Football, soccer, baseball, hockey, gymnastics, ice skating?____

I HEREBY AUTHORIZE THIS OFFICE AND IT'S DOCTOR(S) TO ADMINISTER CARE AS THEY DEEM NECESSARY TO MY SON/DAUGHTER/WARD. I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS OFFICE AND THAT I WILL PAY FOR ALL SERVICES AS THEY ARE PERFORMED. X-RAYS AND ORIGINAL RECORDS REMAIN THE PROPERTY OF THIS OFFICE.

Date:_________________ Signature:____

Print Name:____