Plum Creek Chiropractic PA

Dr. Cindy Shepard

952-461-3675 *www.plumcreekchiro.com*

Child's Name (last, first. middle): _____

Mother's Name (last, first. middle):

_____

Father's Name (last, first, middle):

_____

Address:

_____

__

Home Phone: _____ Mother's work phone: _____Fathers Work phone:

_____

Cell Phone_____

email_____

Date of Birth: _____ /_____/ Age: _____

Gender: M F Social Security_____

Number of Siblings: _____

Type of Birth: Normal vaginal Suction

Drug Induced Pain Meds

Birth Weight: _____

Birth Length: _____

Current Weight_____ _

Current Length_____

Forceps

Prolonged labor

Hospital

Breech.

Short labor

Problems during pregnancy

Problems during labor/de1ivery:

APGAR Scores: _

Congenital anomalies/defects: _____

Infant feeding: Breast

Birthing Center

Was there presence at birth of Jaundice (yellow) Cyanosis (blue)

Bottle

Formula Other

Number of hours child sleeps per night: _____

Obstetrician/Midwife (name, phone number) _____

Pediatrician/Family MD (phone number): _____

Date of last visit to MD: _____Purpose: _____

Immunization History_____

Has your child ever been treated on an emergency basis: Yes No

Describe_____

_____

Quality of sleep: Good ___Fair _____Poor ____

Naps: _

Authorization for Care of a Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed: _____ Witnessed: _____ Date: _

I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed.

X-rays remain the property of this clinic.

Signature: _____ Date: _____

Pregnancy/
History:_____

_____

_____

_____

Delivery/
BirthHistory:_____

_____

_____

Accidents/
Injuries_____

_____

_____

Surgeries_____

_____

Medications:_____

_____

Supplements_____

_____

Family History of (circle all that apply): Heart Disease Lung Disease Diabetes Cancer Depression

Other: _____

Developmental History; At what age did this child:

Respond to Sound: _____ Follow an object with eyes: _____ Hold Head up: _____ Sit Alone: _____

Crawl: _____ Stand: _____ Walk Alone: _____

Childhood diseases (with approximate age)

Chicken Pox: _____ Rubella: _____ Mumps: _____Measles: _____

Whooping Cough: _____ Other: _____

Has this child ever suffered from?

Dizziness	Backaches	Heart Trouble	Chronic Earaches	Diabetes	Tuberculosis
Hypertension	Colds/Flu	Arthritis	Headaches	Asthma	Allergies
Neuritis	Sinus trouble	Constipation	Diarrhea	Anemia	Digestive Disorders
Poor Appetite	Hyperactivity	Bed Wetting	Convulsions	Paralysis	Rheumatic Fever
Fainting	Walking Problems	Broken Bones	Neck Problems	Arm Problems	Leg Problems
Growing Pains	Joint Problems	Behavioral Problems			

Present History:

Does anyone in your house smoke? Yes no

What are this child's favorite foods?

_____

What is this child's typical diet? _____

_____

Number of Bowel Movements a day? _____ Number of urinations a day? _____

Is there anything else I should know?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____