KING CHIROPRACTIC
Spine & Wellness Center

7801 East Bush Lake Road Suite #280
Bloomington, MN 55439

ABOUT THE PATIENT: **0-3 YEARS**

Child's Name: _____ **Today's Date:** _____
Parent Name (1): _____ **Parent Name (2):** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home Phone: _____ **Parent Cell Phone:** _____ **E-Mail Address:** _____
Birthdate: ___/___/___ **Age:** _____ **Current Height:** _____ **Current Weight:** _____ **Gender:** ❑ **M** ❑ **F** ❑ _____
Our aim is to create a safe environment for our members and their families, is there anything you'd like to specifically and explicitly let us know? _____
Homelife: ❑ **Traditional Family (1 home)** ❑ **Single Parent** ❑ **Extended Family** ❑ **Stepfamily (2+ home)**
Number of Siblings: _____ **Names and Ages:** _____
Who may we thank for referring you in? _____ **Has the child ever been to a chiropractor?** ❑ **No** ❑ **Yes**
Your Employer: _____ **Type of Work:** _____
Emergency Contact: _____ **Phone #:** _____

- I authorize the doctor(s) or staff to render care as deemed appropriate for me and / or my child.
- I authorize **King Chiropractic** to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ■ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ _____
Parent / Guardian Signature (this represents a long term authorization for all occasions of service) **Date**

MOTHER'S PREGNANCY AND FERTILITY HISTORY

Any fertility issues / treatments?	❑ No	❑ Yes	If yes, please explain: _____
Any ultrasounds?	❑ No	❑ Yes	If yes, please explain: _____
Any illnesses during pregnancy?	❑ No	❑ Yes	If yes, please explain: _____
Did mother exercise during?	❑ No	❑ Yes	If yes, please explain: _____
Did mother drink during?	❑ No	❑ Yes	If yes, how many / week? _____
Did / does mother smoke?	❑ No	❑ Yes	If yes, how many / week? _____
Did / does father smoke?	❑ No	❑ Yes	If yes, how many / week? _____

MOTHER'S LABOR AND DELIVERY HISTORY

Name of child's current primary Doctor(s): _____
Date of last visit ____/____/____ **Reason:** _____
Complications during pregnancy: ❑ **No** ❑ **Yes** **Explain:** _____
Medication during pregnancy / delivery: ❑ **No** ❑ **Yes** **List:** _____
Child's birth was: ❑ vaginal birth ❑ scheduled C-section ❑ emergency C-section
Location: ❑ at home birth ❑ at a birthing center ❑ at a hospital ❑ other: _____
Child's birth weight: _____ lbs. oz. **Child's birth height:** _____ in. **APGAR score** at birth: _____ after 5 min: _____
At how many week's was your child born? _____ Obstetrician / Midwife's Name: _____
Please, let us know if any interventions or complicates were utilized:
❑ Breech Induction ❑ Pain Meds ❑ Epidural ❑ Episiotomy ❑ Vacuum Extraction ❑ Forceps ❑ Medical Induction ❑ Pitocin
Please describe any other concerns or notable remarks about your child's labor and/or delivery: _____

PARENT'S FAMILY HISTORY

Father's Side: ❑ Heart Disease ❑ Cancer ❑ Diabetes ❑ Heavy Medication Use ❑ Arthritis ❑ Other _____
Mother's Side: ❑ Heart Disease ❑ Cancer ❑ Diabetes ❑ Heavy Medication Use ❑ Arthritis ❑ Other _____

CHILD'S GENERAL HEALTH HISTORY

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Patient Name: _____ ***Mark the conditions that apply.***

Past	Present		Past	Present	
❑	❑	Headaches / Migraine	❑	❑	Vision Problems
❑	❑	Dizziness / Vertigo	❑	❑	Grating of Neck
❑	❑	Nervousness	❑	❑	Stomach Disorders
❑	❑	Ear Infections	❑	❑	Night Terrors / Sleeping Problems
❑	❑	Colic	❑	❑	Growing Pains
❑	❑	Bowel Problems	❑	❑	GERD
❑	❑	Trouble Eating	❑	❑	Rashes
❑	❑	Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Temper Tantrums
❑	❑	Recurring Fevers	❑	❑	Sensory Processing Issues
❑	❑	Throat Issues	❑	❑	ADD / ADHD
❑	❑	Abnormal Fatigue / Depression	❑	❑	Abnormal Appetite
❑	❑	Digestive Problems	❑	❑	Seizures
❑	❑	Bed Wetting	❑	❑	Scoliosis
❑	❑	Difficult Breast Feeding	❑	❑	Nausea / Vomiting
❑	❑	Heart Disorders	❑	❑	Torticollis
❑	❑	Latching / Nursing Problems	❑	❑	Tongue / Lip Tie
❑	❑	Autism Spectrum Disorder	❑	❑	Bladder Problems
❑	❑	Chronic Colds / Sinus Problems	❑	❑	Epilepsy
❑	❑	Other _____			

Known ALLERGIES or FOOD INTOLERANCE: _____

ANTIBIOTIC courses: ❑ No ❑ Yes taken in the last 6 mo. ___ Total during lifetime _____ Reaction: _____

BEHAVIORAL, SOCIAL, or EMOTIONAL issues? ❑ No ❑ Yes Reaction: _____

Diet: ❑ Mostly whole, organic foods ❑ Pretty average ❑ High amount of processed foods

List any MEDICATIONS being taken: _____

VACCINATIONS: ❑ No ❑ Yes; alternate ❑ Yes; schedule Reaction: _____

Has any Doctor / Professional advised you to "Take your child to a Chiropractor?" ❑ No ❑ Yes - Name: _____

GROWTH AND DEVELOPMENT HISTORY

Is / was your child breastfed ❑ No ❑ Yes If yes, how long: _____

Difficulty with breastfeeding ❑ No ❑ Yes If yes, please explain: _____

Did they ever use formula? ❑ No ❑ Yes At what age? _____ What type? _____

Frequently arch their neck / back, feel stiff or bang their head? ❑ No ❑ Yes Explain: _____

What age: Respond to noise: __ Follow objects: __ Hold head up: __ Vocalize: __ Teethe: __ Sit: __ Crawl: __ Walk: __ Start cow's milk: __ & solid food: __

CHILD'S PAST TRAUMATIC HISTORY

List any past AUTO collisions / dates: _____ **Was any care received?** _____

Please list child's HOSPITALIZATION and SURGICAL history, include year: _____

Any MAJOR INJURIES, ACCIDENTS, FALLS or FRACTURES: _____

_____

REASON FOR SEEKING CARE

Please describe health concern(s): _____

When did the condition first begin? _____ **How did the problem start?** ❑ Suddenly ❑ Gradually ❑ Post-Injury

Has your child ever received care for this condition before? ❑ No ❑ Yes **Explain:** _____

What makes the problem better: _____

What makes the problem worse: _____

Top health goals for your child:

1. _____
2. _____
3. _____