Reilly Chiropractic, 4751 W. Park Ave., Chippewa Falls, WI 54729

Phone (715)723-2892 Fax (715)723-3540

PATIENT INFORMATION

Date: _____

Child's Name: _____ Birth Date: _____/_____/_____ Gender: ☐ M ☐ F

Parent's Name(s) _____

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Cell Phone: ( ) _____

Email Address: _____

How were you referred to this office? _____

HEALTH HISTORY

3 years old and Younger

Birth Place: Home Hospital Birth Center Other: _____

Delivered by: Mid-wife OB/Gyn Other: _____

Type of Birth: Vaginal C-section

Procedures used during labor: ☐ Forceps ☐ Vacuum Extraction ☐ Pain Relief (type) _____

Delivery Complications: _____

Ultrasound during pregnancy? ☐ Yes ☐ No If Yes, how many? _____

Is/Was your child breast-fed? ☐ Yes ☐ No If Yes, how long? _____

Is/Was there an intolerance or allergy to formula or foods? ☐ Yes ☐ No If Yes, to what? _____

Did your child reach developmental milestones (crawling, walking, talking, etc.) at appropriate ages? ☐ Yes ☐ No

According to the National Safety Counsel, approximately 50% of infants fall head first from a high place (bed, couch, changing table, etc.) during the first year of life. Has this happened to your child? ☐ Yes ☐ No

Has your child been involved in a motor vehicle accident of any kind? ☐ Yes ☐ No

Has your child had surgery? ☐ Yes ☐ No If Yes, for what? _____

Has your child been seen by either a doctor or hospital on an emergency basis? ☐ Yes ☐ No If Yes, please explain_____

_____

Does your child have any learning challenges? ☐ Yes ☐ No If Yes, what are they? _____

_____

3 Years old and Older

Does your child participate in sports? ☐ Yes ☐ No If Yes, which one(s)? _____

_____

Does your child experience any other types of physical activity? ☐ Yes ☐ No If Yes, what types? _____

_____

Does your child carry a backpack? ☐ Yes ☐ No

Does your child watch television? ☐ Yes ☐ No If Yes, approximately how many hours per week? _____

Does your child play video games? ☐ Yes ☐ No If Yes, approximately how many hours per week? _____

All Ages

Does your child take vitamins or supplements? □ Yes □ No If Yes, please list: _____

_____

Approximately how many prescriptions of antibiotics has your child taken:

during the last 12 months? _____ during their lifetime? _____

Approximately how many other prescription medications has your child taken:

during the last 12 months? _____ during their lifetime? _____

Please list the reasons: _____

Approximately how many over-the-counter medications has your child taken (ex. Tylenol, Ibuprofen, etc.):

during the last 12 months? _____ during their lifetime? _____

Please list the types: _____

If your child currently taking any medications? □ Yes □ No If Yes, please list: _____

_____

Is your child exposed to cigarette smoke? □ Yes □ No If Yes, how often? _____

Vaccinations: After careful consideration of the literature and facts, some parents choose not to have their children vaccinated.

Has your child been vaccinated? □ Yes □ No If Yes, please answer the following:

At what age did they receive their first vaccine? _____

Are the vaccines current? □ Yes □ No

Has your child ever had a reaction of any kind to a vaccination? □ Yes □ No If Yes, what type? _____

Circle any of the following your child has experienced in the last 12 months:

Ear infection	Scoliosis	Seizures	Chronic cold	Asthma	Allergies	ADD
ADHD	Colic	Psoriasis	Diabetes	Headaches	Bed wetting	Back discomfort
Growing Pains	Eczema	Hearing difficulties	Digestive problems		Mood swings	Temper Tantrums
Visual impairments	Recurring fevers					