PARENT/CHILD COMPREHENSIVE HEALTH PROFILE

Name of Parent: _____ Name of Child: _____

Address: _____

City/State/Zip: _____

Phone # Work: _____ Cell: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: M F

How did you hear about our office? _____

Has your child ever received spinal adjustments by a Chiropractor before? Y N

If yes, when and by whom? _____ How long did your child go? _____

Have you or your spouse ever received chiropractic care? Y N

What other natural forms of healthcare has your child received? _____

What do you hope for your child to receive from chiropractic care in this office? _____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR CHILD'S HISTORY

Were you physically ill prior to or during the pregnancy? Y N

Was the pregnancy difficult? Y N

Did you have any falls, accidents, or physical injuries during the pregnancy? Y N

Was your labor chemically induced? Y N

Were you conscious/semiconscious/unconscious?

Was the birth: ___drug induced ___forceps or suction ___"C" section ___breech

___natural ___prolonged ___cord around the neck

Was the birth: ___at home ___in a birthing center ___in a hospital ___other

Was your child incubated or isolated? Y N
Was your child: ___bottle fed ___breast fed ___other

Has your child experienced any of the following (If so please list when and any further comment you wish to share):

__Headaches __Allergies __Ear infections __Breathing problems __Fatigue __Irritability

__Hyperactivity __Flu __Frequent colds __Bloody noses __Meningitis __Diarreaha __Colic

__Constipation __Rashes __Milk or lactose intolerance __Bed Wetting __Asthma

__Sleeping disorders __Digestive problems __Other

Regarding your child today:

Has your child ever been unconscious? Y N

Has your child ever used crutches or corrective braces? Y N

Is your child accident-prone? Y N

Has your child had any falls down steps? Y N

Has your child ever been involved in an auto accident? Y N

Has your child ever been hospitalized or had surgery? Y N

Has your child ever had any broken bones or sprain injuries? Y N

Is your child on any medications? Y N

Has your child been vaccinated? Y N

Is your child active in any particular sports? If yes, which ones_____

Is your child hyperactive? Y N

Does your child have learning disorders? Y N

Is your child nervous or has anyone suggested that your child is nervous?

How would you rate your child's physical health?

__excellent __good __fair __poor __getting better __getting worse

How would you rate your child's emotional/mental health?

__excellent __good __fair __poor __getting better __getting worse

Is there anything else you wish to share that may help us to better understand your child?

_____

I hereby authorize Dr. Carmen Mazza and whomever she may designate to administer care as she deems necessary to my son/daughter.

Signed_____ Witnessed: _____

Dated this _____ Day of _____ 20___