CONYERS HOLISTIC
CHIROPRACTIC & NUTRITION

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Thank you for allowing us the opportunity to take care of you and your family. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name _____ SS# _____
Name of Parents/ Guardians _____
Address_____ City _____ State_____ Zip _____
Home Tel _____ Parent Work Tel _____
Email _____
Patient Date of Birth _____ Sex M / F Height _____ Weight _____ # of Siblings _____ How did you hear about our office? _____
Reason(s) for seeking care _____
Other doctors seen for this condition (circle) Yes / No
If yes, doctor's names and prior treatment:

_____
Other Health Problems: _____

Has your child ever suffered from (circle all that apply):

- Dizziness	- Diabetes	- Arthritis	- Neuritis	- Anemia	- Poor Appetite
- Bed Wetting	- Fainting	- Neck Problems	- Joint Problems	- Backaches	- Tuberculosis
- Headaches	- Digestive Problems	- Rheumatic Fever		- Hyperactivity	- Convulsions
- Colic	- Walking Problems	- Arm Problems		- Blood Disorders	- Asthma
- Heart Problems	- Hypertension	- Sinus Trouble		- Orthopedic Problems	- Broken Bones
- Paralysis	- Leg Problems	- Stomach Aches		- Chronic Earache	- Frequent Colds/Flu
- Allergies	- Constipation	- Diarrhea		- Behavioral Problems	- Muscle Jerking
- Ruptures/ Hernias		- "Growing Pains"			

- Other (Please list): _____

FAMILY HEALTH HISTORY

Previous Chiropractor(s):

_____
Reason for Care _____
Were you satisfied with the care your child received there? Yes / No
Name of
Pediatrician:_____
Reason for Care _____
Are you satisfied with the care your child received there? Yes / No
Number of antibiotics you child has taken:
During the past 6 months _____ Total during his/her lifetime _____

Number of doses of other prescription medications your child has taken:
During the past 6 months _____ Total during his/her lifetime _____ Vaccination History
_____

PRENATAL HISTORY

Type of Birth Attendant: OB/GYN / CNM / Lay Midwife
Name _____
Location of Birth: Home / Birthing Center / Hospital
Complications during pregnancy: Yes / No List _____
Ultrasound during pregnancy: Yes / No
Medications during pregnancy/ delivery: _____
Cigarette / Alcohol use during pregnancy: Yes / No
Birth Intervention: Forceps / Vacuum
Cesarean: Yes / No Planned or Emergency: _____
Complications during delivery: Yes / No
Genetic disorders or disabilities: Yes / No If so, please list: _____
Birth weight _____ Birth length _____
APGAR scores _____

FEEDING HISTORY

Breast Fed: Yes / No How long? _____
Formula Fed: Yes / No How long? _____
Type of formula:_____
Introduced to solids at _____ months, Cow's milk at _____ months
Food/ juice allergies or intolerances: Yes / No List _____

DEVELOPMENTAL HISTORY

Number of hours sleeping per night _____ Quality of sleep: Good / Fair / Poor
At what age was your child able to: Respond to sound _____ Respond to visual stimuli _____
Hold head up _____ Sit up _____ Cross crawl _____ Stand alone _____ Walk alone _____.

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.) Was this the case with your child? Yes / No

Is/has your child been involved in any high impact or contact type sport? Yes / No
Has your child ever been involved in a car accident? Yes / No
Other traumas not described above: Yes / No If yes, list trauma: _____ Date: _____
Prior surgery: Yes / No If yes, Type and Date: _____

CHILDHOOD DISEASES

Chicken Pox Y / N Age _____ Rubella Y / N Age _____ Rubeola Y / N Age _____
Mumps Y / N Age _____ Whooping Cough Y / N Age _____ Other_____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctor(s) to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed _____

Witnessed _____ Date _____