

Record # _____

Name	Today's Date	Birthdate	Age		
Guardian Name	# of kids / ages				
Address	City	State	Zip		
Home Phone Cell Phone	Occupation		Gender □ M □ F □ O		
E-Mail Have they been	to a chiropractor before?	□ Yes □ No			
Who May We Thank For Referring You To Our Office:					
PRESENT COMPLAINTS (Please fill out in as much detail as possible If the child is to young to fill out the complaints move past them and fill out explanation for evaluation:					
1	How long has	this been an issue?			
Is it: □ Constant (100%) □ Frequent (50-75%) □ Occasional (25-50%) □ Intermittent (1-25%) Worse □ Morning □ Mid-day □ Night □ Dull □ Sharp □ Ache □ Stabbing □ Numb/Tingle □ Burn □ Other □ Pain radiates to: □ □ Staying the same □ Getting worse □ Improving Pain Scale: NO PAIN 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 WORST PAIN Relieved by:					
Previous Episodes: Yes No Details:					
Previous Care for this condition: □ Yes □ No	Recent 1	「 esting: □ Yes □ No			
2	How long has	this been an issue?			
Is it: □ Constant (100%) □ Frequent (50-75%) □ Occasiona □ Dull □ Sharp □ Ache □ Stabbing □ Numb/Tingle □ Burn □ Staying the same □ Getting worse □ Improving Pain Scanne Relieved by:	Other ale: NO PAIN 0 - 1 - 2 ravated by:	□ Pain radiates to: _ - 3 - 4 - 5 - 6 - 7 - 8 - 9	- 10 WORST PAIN		
Previous Care for this condition: ☐ Yes ☐ No			-		
Previous Care for this condition: □ Yes □ No Details of the complaint: (IF COULD NOT BE FILLED OUT IN	Recent 1	「esting: □ Yes □ No	-		
	Recent 1 THE ABOVE SECTION) aily Routine Sitting ed pain by the guardian:	Please ma			
Details of the complaint: (IF COULD NOT BE FILLED OUT IN Does the condition affect his or her: □ Sleep □ Eating □ Da What makes it better? What makes it worse? What doctors have you seen for this: Type of treatment: If the patient cant give verbal or visual pain level: What is the perceiv	THE ABOVE SECTION)	Please ma	ark all areas of concern:		



74 Main St. | Medway, MA 02053

Record # _____

Patien	t Nam	e					Da	te:
PATIENT HISTORY □ NO MEDICAL PROBLEMS - No prior history of any significant medical problems: Initial:								
Mark t	he co	nditions that apply to you:						
Past			Past	Pres		Past		esent
		Headaches			Vision Problems			Dizziness/Fainting
		Ear Infections			Sleeping Problems			Neck Issues
		Colic			Growing Pains			Back Issues
		Allergies / Asthma			Dental Problems			Arm/Leg Issues
		Medication Side Effects			Temper Tantrums			Reflux
		Recurring Fevers			ADHD			Constipation
		Digestive problems			Seizures			Diarrhea
		Bed Wetting			Scoliosis			Poor Posture
		Chronic Colds/Sinus			Ever Needed Stitches			
		Other						
□ Car	icer (p	lease give details):						
l ict on	v ma	lications being taken:						
		ourses of antibiotics child has taken in the						
		::: Current				ing incume.		
		pediatrician Visit:// Re						
		diatrician/obstetrician/midwife:						
	-	Birth: ☐ Hospital ☐ Birthing Center		Home				
		ns during pregnancy: □ No □ Yes Ex						
-		during pregnancy: □ No □ Yes	-					
		during pregnancy/delivery □ No □ Ye		-				
		cohol use during pregnancy: □ No □		-				
-		t auto collisions:			Was any care	received?		
List any past falls/bumps/bruises: Was any care received?								
List any past sport, recreational, or home injuries:								
		ribe any past conditions and treatment re						
		••						
Please	list a	ny past hospitalizations and surgeries:						
Father	's side	e: Heart Disease Cancer Diabete	es 🗆 H	leavy I	Medication use □ Arthritis □	Other		
Mother's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis Other Is there any other family history you want us to know?								
• • • • • • • • • • • • • • • • • • • •								
Patient	Patient/Guardian Signature Dr. Signature							
1 autil	Jud	adian dignature			Di. Signature			

IS YOUR CHILD TRYING TO TELL YOU SOMETHING?

Please check off all that	
apply: Impulsive Aggression Withdrawal Cannot sit still Can't follow instructions Rocking/head banging	□ Defiant □ No care for consequences □ Overly self-conscious □ Detached from family □ Unable to handle disappointment
☐ Temper tantrums/meltdowns ☐ Reckless, can't control actions ☐ Bites nails, picks or cuts skin ☐ Damages property ☐ Feeling helpless ☐ Eating	□ Lack of respect to parents, teachers □ Difficulty making friends □ Distorted thinking □ Disrupts class □ Deceitfulness □ Anti-social
Develops physical symptoms in response to emotional issues Social phobia/other phobias Inappropriate feelings Inability to sleep Light/sound sensitivity Fussy about textures Anxiety Tics, constant movement Fearful of crowds, strangers, new environment, altered routine	Difficulty concentrating Learning disability (dyslexia, ADHD, etc.) Difficulty with logic/reasoning Poor executive brain function Lost interest in school Language delays Frequent/prolonged illness Poor memory Headaches, stomach-aches, joint pains, fatigue Severe reactions to minor infections Auto-immune problems (cancer, lupus, diabetes, etc.) Chronic cough/ruppy pose
Clumsy/poor coordination Insensitive to touch/pain Developmental delays Skills Skills	☐ Skin conditions

YOUR CHILD COULD BE EXHIBITING SYMPTOMS OF NERVOUS SYSTEM DISTRESS.
WE WANT TO HELP YOU GET YOUR CHILD BACK!



IN YOUR OWN WORDS, PLEASE TELL US MORE ABOUT YOUR CHILD AND THE SIGNS THEY HAVE BEEN EXHIBITING:

ANYTHING ELSE WE SHOULD KNOW?

