



Hatboro Family Wellness
2 Home Road Hatboro, PA 19040
(215) 444-0441
www.HatboroWellness.com

Personal Information

Child's Name: _____ Nickname: _____ Date: _____

Parent(s) Name: _____

Sibling's names and ages: _____

Parent's marital status: Married Single Divorced Widowed e-mail: _____

Child's Age: _____ Current Height: _____ Weight: _____ Birth date : _____ Sex: M F

Address: _____ City: _____ Zip: _____

Home Phone: _____ Other Number: _____

Family doctor's name: _____ Address: _____

Who may we thank for referring you? _____

Has your child ever received chiropractic care? Yes No If yes, date of last visit: _____

If yes, who is your child's previous Doctor of Chiropractic? _____

Please check the purpose for your child's visit: crisis management early detection of problems
 prevention wellness maximizing normal growth and development Other: _____

Health Objectives

Major _____ Minor _____

Is this problem: occasional frequent constant intermittent

What makes this worse? _____ Better? _____

Is the problem worse during a certain time of the day? Yes No If Yes, when? _____

Does this interfere with the child's sleep? Yes No Eating? Yes No Daily routine? Yes No

Is this becoming worse? Yes No

Birth History

Child's gestational age at birth? _____ weeks. Birth weight _____ lbs _____ oz Birth length _____ inches

Was your child's birth: at home in a birthing center hospital

Was the birth attended by a: medical doctor/OB midwife

Duration of birth: _____ hours Duration of Pushing: _____ hours

Was child born: vaginally c-section If c-section why? _____

Were there any complications? Yes No

If Yes, please explain _____

Assistance used during delivery: Forceps Vacuum extraction Episiotomy

Was labor: spontaneous induced

Were medications given to the mother during birth? Yes No Epidural? Yes No

Growth & Development

Was the infant alert and responsive within 12 hours of delivery? Yes No

If no, please explain _____

At what age did the child: Sit alone: _____ months Walk: _____ months

Crawl: _____ months For how long? _____ months Does your child sleep on: front back side

Family Health History

Please note any health problems that are present in:

Mothers family: Heart Dz High BP Cancer Stroke Diabetes Anxiety/Depression

Fathers family: Heart Dz High BP Cancer Stroke Diabetes Anxiety/Depression

Siblings: Heart Dz High BP Cancer Stroke Diabetes Anxiety/Depression

List any other diseases that "run in your family" _____

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

Physical Stressors

Any traumas to the mother during pregnancy? (ie. falls, accidents, etc.) Yes No

If yes, please explain _____

Any evidence of birth trauma to the infant? bruising odd shaped head stuck in birth canal
 fast or excessively long birth respiratory depression cord around neck

Any falls from couches, beds, change tables, etc? Yes No

If yes, please explain _____

Any injuries resulting in bruises, cuts, stitches or fractures? Yes No

If yes, please explain _____

Any hospitalizations or surgeries? Yes No If yes, please explain _____

Any sports played? List: _____

Is a school backpack used? Yes No Is it heavy or light?

Psychosocial Stressors

Any difficulties with lactation? Yes No Any problems with bonding? Yes No

Any behavioral problems? Yes No _____

Any night terrors, sleep walking, difficulty sleeping? Yes No _____

How many hours of sleep per 24 hours? _____ Age of child when began daycare? _____

Average time watching TV or video games per week? _____

Do you feel that your child's social and emotional development is normal for their age? Yes No

If no, explain: _____

Chemical Stressors

Was this child breast-fed? Yes No If yes, how long: _____

If nursed, did the child ever favor one breast over the other? Yes No Which side? _____

Formula introduced at what age: _____ Which formula? _____

Introduction of cow’s milk at what age: _____ Began solid foods at what age: _____

Types of solid foods: _____

Food/Juice intolerance? Yes No Type: _____

Is your child ever taken any medications? Yes No Type: _____

Vaccines? Yes No _____

Review of Systems

Often seemingly unrelated symptoms can manifest as other health concerns. Please indicate if your child has had any of the following. **Circle current and check past conditions.**

- headaches
- dizziness
- irritability
- fatigue
- depression
- loss of balance
- sleeping problems
- fainting
- poor coordination
- loss of taste
- loss of smell
- allergies
- Other: _____
- asthma
- sinus congestion
- frequent colds
- sore throats
- ear pain/infections
- fevers
- cold sweats
- bronchitis
- pneumonia
- difficulty breathing
- constipation
- diarrhea
- weight loss
- weight gain
- heartburn
- heart palpitations
- chest pressure
- numbness in feet
- numbness in hand(s)
- numbness in leg(s)
- dental problems
- loss of memory
- loss of concentration
- urinary problems
- vision changes
- ears ringing
- weakness
- upper back pain
- lower back pain
- neck pain
- joint pain
- reduced mobility
- muscle cramps
- radiating pain
- stiffness
- growing pains

Please list any other questions or concerns which you have, you may write them in the space below.

Insurance Assignment of Benefits

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to *Hatboro Family Wellness* all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

I authorize the use of my signature on all insurance submissions. I further authorize *Hatboro Family Wellness* to use my healthcare information and disclose information to your insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I am also informed at this time I have the right to withdraw my name from this signature on file agreement at anytime when I have notified this office in writing.

Guardian Signature _____ **Date** _____