Welcome *to Synaptic Chiropractic, PA*

Name: _____ Nickname: _____ Current age: _____ Date of Birth: _____

Child's Home Address _____ City _____ State _____ Zip _____

Parent #1 _____ Phone (h) _____ (work) _____ (cell) _____

Parent #2 _____ Phone (h) _____ (work) _____ (cell) _____

Parent's Email _____

Child's Sex at Birth : Male O Female O Prounoun: _____

Purpose of the appointment with doctor today: _____

Has child ever received chiropractic care? (Please circle) Yes O No O Referred by _____

If Child was adopted: ***Adoption Information***

Child's age when adopted _____ Date of Adoption _____

Known health history of child _____
(Use back of page for additional information as needed)

Pregnancy Information

Pregnancy History: _____
Pre-natal Supplements? Yes O No O Omega 3 Supplement? Yes O No O Pro-biotic Supplement? Yes O No O
Organic Diet? Yes O No O Any Prolonged Emotional Stress During Pregnancy? Yes O No O
Any Loss Suffered During Pregnancy? (Example: death, loss of job or pet) Yes O No O Comment: _____

Medications taken during pregnancy? _____
Any problems during pregnancy and/or labor? (Use back of page for additional information as needed)
_____

Delivery/Birth History: _____

Birth Information

Birth Weight: _____ Birth Length: _____ Epidural: Yes O No O
Type of Birth: Vaginal O Forceps O Breech O Cesarean O Home O Birthing Center O Hospital O
Apgar Scores: _____ Jaundice (yellow) at Birth? Yes O No O Cyanosis (blue) Yes O No O

Congenital Anomalies/Defects: _____

Infant Feeding: Breast O For how long? _____ Bottle O Which Formula? _____

Any issues with feeding? _____

Number of hours child sleeps daily: _____ Quality of Sleep: Good O Fair O Poor O

Has child had any vaccinations? _____

Number of Siblings: _____ Siblings Name, Age and Sex: _____

Date of last visit to any doctor: _____ Reason for that visit: _____

Has child ever been treated on an emergency basis? _____

At what age did child respond to sound: _____ Crawl: _____ Follow object with eyes: _____

Hold head up: _____ Stand: _____ Sit Alone: _____ Walk Alone: _____

Current Health Habits

Yes	No		Comments	*Notes by Doctor*
O	O	Diet (Eating healthy foods)?	_____	_____
O	O	Has child been in any accidents?	_____	_____
O	O	Exercise Regularly?	_____	_____
O	O	Hobbies/Sports injuries?	_____	_____

Sleeping Posture: O Side O Stomach O Back (Comment) _____

How are things going at school? (Comment) _____

Performance: O Good O Poor (Comment) _____

Interaction: O Good O Poor (Comment) _____

Does child have emotional stress? Family O School O Other _____

Any Present Complaints: _____

Pain or Problem started on _____Feels like: _____ Sharp Dull Ache Burns Numbness

Is condition interfering with school? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition getting progressively worse? _____ Using any home remedies? _____

⇨ Please note **ANY** of the following signals that have presented, even if you feel they are unrelated:

<Under-Aroused>	*<Un-Stable>*	*<Over –Aroused>*
O Poor Attention	O Migraines	O Cold hands
O Impulsive	O Headaches	O Cold feet
O Easily Distracted	O Seizures	O Tight Muscles
O Disorganized	O Sleepwalking	O Teeth grinding
O Depressed	O Hot flashes	O Anxiety
O Lacking motivation		O Heart Palpitations
O Poor Concentration	O Food sensitivities	O Restless Sleep
O Spaciness	O Bed wetting	O Poor expression of emotions
O Constipation	O Eating Disorder	O poor immune system
O Low Pain Threshold	O Bipolar Disorder	O Racing Mind
O Difficulty waking up	O Mood Swings	O High Blood Pressure
O Worry	O Panic Attacks	O Accelerated Aging
O Irritable		O Irritable Bowel
O Low Energy		

<Exhausted>		
O Cancer	O Rheumatoid Arthritis	O Diabetes
O Depression	O Chronic Fatigue Syndrome	O Epstein-Barr Syndrome

O Eczema or Skin problems	O Pins & Needles in Legs or Arms	O Buzzing in Ears	O Vision Problems
O Low Blood Pressure	O Loss of Smell or Taste	O Dyslexia	O Loss of Memory
O Numbness in Fingers & Toes	O Diarrhea	O Dizziness or Fainting	O Sinus Problems
O Shortness of Breath	O Loss of Balance	O Face Flushed	O Bladder Problems
O Ear Infections	O Urinary Infections	O Speech Difficulty	O ADHD or ADD

Has child been under drug and medical care? _____

What medications does the child take? _____

How long has child been taking them? _____ Side effects noticed: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine my child for further evaluation:

_____ _____ _____

Signature (Parent or Guardian) Printed name of person completing this form *Date*