anunson
chiropractic

Date _____

Pediatric Evaluation: Parent's Form

anunsonchiropractic@gmail.com // 608.829.2250 // 8215 Plaza Drive, Suite B // Madison, WI 53719

Welcome to Anunson Chiropractic

Child's First Name _____ MIddle Initial _____ Last Name _____

Sex: Male / Female Birthdate _____ Previous Chiropractic Care? Yes No

Address _____ City _____ St _____ Zip _____

Parent/Guardian's Name(s) _____

Mother

Home # _____ Address _____

Work # _____ City _____

Cell # _____ St _____ Zip _____

Preferred? H / W / C Email _____

Father

Home # _____ Address _____

Work # _____ City _____

Cell # _____ St _____ Zip _____

Preferred? H / W / C Email _____

Responsible for account/insurance: Mother _____ Father _____

Occupation _____ Employer _____

Address _____ City _____ St _____ Zip _____

Whom may we thank for referring you to our office? _____

Your Child's Health Profile

List your child's chief complaints / the reason you consulted our office in order of severity:

1) _____ For how long? _____

2) _____ For how long? _____

Pediatrician _____ Phone _____

List other doctors (medical, chiropractic, other) you have consulted for these conditions:

1) _____ Clinic/Address _____

2) _____ Clinic/Address _____

List any over the counter and prescription medications your child is taking:

Medication _____ Reason _____

Medication _____ Reason _____

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Your Child's Health History

Let's begin at birth: A German Medical researcher discovered that over 80% of the infants that he examined shortly after birth were suffering from injuries to the cervical spine, the neck, causing all types of health problems.

Were you born: _____ in a hospital? _____ at home?

Were you premature? *Yes* *No* Number of weeks? _____

Who was present at your birth: _____ Obstetrician _____ Midwife _____ Dad _____ Other family

Were any instruments used for your delivery? *Yes* *No* Forceps *Yes* *No* Vacuum Extractor *Yes* *No*

Was your mother given any drugs during delivery? *Yes* *No*
If yes: _____ to numb from waist down? _____ to sedate?

Were drugs used to get her labor started? *Yes* *No*
If yes, what was the reason? _____

You were late? *Yes* *No* Number of weeks? _____

Mom had toxemia? *Yes* *No*

Other _____

Were you born Cesarean Section? *Yes* *No*

Emergency _____ Planned _____

Was your presentation on delivery: _____ Head first _____ Feet first _____ Breech _____ Buttocks first

How many hours from beginning to end was your labor? _____

How does your mother describe your delivery? _____

_____

Following your delivery was there: _____ Bruising on head _____ Neck/face _____ Malformation of skull/face

Broken bones or other injury from delivery _____

Were you considered a sickly child? *Yes* *No*

Were you breast fed? *Yes* *No* If so, for how long? _____

What was your early history of sickness? Y=Yes N=Never S=Seldom F=Frequent A=Always

_____ Colic	_____ Pneumonia	_____ Upper Respiratory Infection/Bronchitis	_____ Tubes
_____ Tonsillectomy	_____ Prone to flu		_____ Tonsillitis
_____ Prone to colds	_____ Ear Infections	_____ Were you given allergy shots	_____ Allergies – what age?

Were you on antibiotics? _____ Never _____ Seldom _____ Frequently _____ Almost all of the time

I hereby authorize this office and its Doctors 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.

_____ _____

Parent Signature Date