Date_____

Parents Name_____

Patient Name_____

Address_____

City_____

State_____ Zip_____

Parents Contact No._____

DOB:_____SSN:_____

Sex ☐ M ☐ F

Birth Weight_____Birth Length_____

Current Weight_____Current Length_____

Type of Birth (circle all that apply):

normal forceps vacuum

c-section breech home

Birth Center_____

Hospital_____

OBGYN/Midwife_____

Pediatrician_____

Date of last visit to MD_____

Purpose of visit listed above_____

Purpose of today's appointment_____

Whom may we thank for referring you to our office?

_____

Pediatric Wellness Profile

Please list the age the child received each method:

Breast_____bottle_____formula_____

No. of hrs sleep per night_____

Quality of sleep good fair some none

Immunization History_____

Pregnancy Complications_____

_____

Labor/Delivery Complications_____

_____

APGAR Scores_____

Was the infant alert and responsive within 12 hrs of delivery?_____

At birth was there: Jaundice Cynosis

Congenital anomalies/defects_____

Any evidences of birth trauma (circle all that apply)

Bruises odd shaped head stuck in birth canal

Fast or long birth respiratory depression

Cord around neck other_____

Any trauma during pregnancy?_____

During pregnancy, did the mother: smoke drink

Take supplements_____

Any falls from crib, bed, changing table_____

Any difficulty w/ lactation_____

Difficulty bonding_____

Behavioral problems_____

Was the infant alert within 12 hrs of delivery_____

***1 yr and older

At what age did the child respond to sound____

Follow an object_____hold head up_____

Vocalize_____Sit alone_____Teethe_____

Crawl_____Walk_____

Age when the child was introduced to

Cows milk____solid foods_____juice_____

Any food/juice intolerances_____

Approximate hours spent at play per day_____

Average no. of hrs of television per day/wk____

Sports played and age began_____

Weight of school backpack_____

Has your child ever been treated on an emergency basis? Yes No
Explain_____

Surgeries_____

Medications_____

Allergies_____

Has the child ever suffered from any of the following (circle all that apply)

Dizziness	Backaches	Heart trouble
Turerculosis	Colds/Flu	High Blood Pressure
Headaches	Poor Appetite	Ear infections
Constipation	Sinus trouble	Digestive Trouble
Anemia	Diarrhea	Orthopedic problems
Asthma	Hyperactivity	Sugar concentration
Paralysis	Muscle jerking	Ruptures/Hernia
Arthritis	Neck problems	Walking problems
Colic	Leg Problems	Growing pains
Neuritis	Blood Disorders	Behavioral problems
Broken bones	Joint problems	Stomach aches
Walking Problems	Convulsions	Rheumatic Fever
Broken Bones	Fainting	Bed-wetting
Diabetes		

Please indicate if someone in the child's immediate Family has any of the following conditions by using M-mother, F-father, S-sister, B-brother

High Blood Pressure	Headaches
Ulcer/digestive problems	Arthritis
Thyroid disorder	Stroke
Back problems	Cancer
Osteoporosis	Diabetes
Heart Disease	Mental Illness

Please share with us what health goals you have for this child. Circle as many as you wish

more energy	freedom from pain
better concentration	more balanced posture
quality vitamins	easier breathing
reduce medications	improve overall health
better sleep	better sports performance
improve nutrition	greater resistance to disease
reduce medications	enhanced emotional well-being
other	improve concentration

berlin wellness group

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

I (the undersigned parents) of _____, a minor, do hereby consent to Berlin Chiropractic Corporation to any physical examinations, chiropractic diagnosis or physiological therapeutics which are deemed advisable by one of our chiropractic physicians.

These authorizations shall remain effective until _____, 20___, unless sooner revoked in writing delivered to said agents.

_____ Signed: _____
Date of Signature Parent/Guardian