

## Welcome to Dobrich Chiropractic & Wellness Center!

Please take a few moments to fill out this form so that we may better serve your child's health care needs.

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Parent's E-mail \_\_\_\_\_

Emergency Contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Child's Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex M F

### What is your goal for bringing your child here today?

Wellness Care  Symptom Relief

### Symptom History (If your child is here for Wellness Care, skip this section, go to Health History)

Which symptoms is your child experiencing?

ear infections  colic  asthma  frequent colds  vomiting  reflux

constipation  diarrhea  urinary tract problems  trouble breast feeding

Autism  Asperger's  allergies  ADD/ADHD

skin, type \_\_\_\_\_  pain, where? \_\_\_\_\_

other \_\_\_\_\_

Please **describe** the symptoms: \_\_\_\_\_

**When** did your child's symptoms appear? \_\_\_\_\_

If known, **how** did your child's symptoms come about? \_\_\_\_\_

If known, what **aggravates** your child's symptoms? \_\_\_\_\_

If known, what **relieves** your child's symptoms? \_\_\_\_\_

**How frequently** do your child's symptoms occur? \_\_\_\_\_

Are the symptoms: Constant or Intermittent

### Health History

Was your child born: vaginally or c-section

Were there any complications during the delivery? \_\_\_\_\_

How long was the labor? \_\_\_\_\_

Have you decided to: **vaccinate your child** or **decline vaccinations**

How many times has your child been on antibiotics in his or her lifetime? \_\_\_\_\_

Please list **ALL** health problems your child **currently** has: \_\_\_\_\_

Please list **ALL** health problems your child has had in the **past**: \_\_\_\_\_

Please list **ALL** medications your child is currently taking and *what he/she is taking each for*: \_\_\_\_\_

Please list **ALL** supplements your child is currently taking and *what he/she is taking each for*: \_\_\_\_\_

Please list **ALL** surgeries that your child has had. *Include the date and reason for each surgery*: \_\_\_\_\_