NAME:	DATE:

DOB:_____ Age:_____ Gender: _____

Parent's names: Mother _____ Father _____

Current Condition

What are the primary complaints/reasons for today's visit?
1.) 2.)

Is it new or chronic?

1.) 2.)

Where is it located? On Left side, right side, both?
1.) 2.)

Describe how it feels (ache, sharp, numb, pressure, tight/stiff, tingling, burning)

1.) 2.)

How bad is the pain on an average day? (1-10 scale)

1.) 2.)

Is it constant or does it come and go?

1.) 2.)

When did it begin? (Approximate Date)

1.) 2.)

Do you know how it started?

1.) 2.)

What caused these problems?
□ Birth injury □ Fall □ Sports Injury □ Allergy □ Infection□ Bend □ Twist □ Lifting
□ Pushing/Pulling □ MVA□ Computer Use □ Work Injury □ Unknown □ Other
Please Describe Details: _____
Are you getting: Better___ Worse___ No Change___ Unsure___

Prior Treatment

	Better	Worse	Same		Better	Worse	Same
Heat				Chiropractic			
Ice				Surgery			
Rest				Injections			
Activity				Orthotics/Lifts			
Exercise				Braces/Helmet			
Stretching				Biofeedback			
Acupuncture				Medications			
Massage				PT/OT			
Osteopathic Treatment				Allergy Shots/ Testing/Treatment			
Counseling				Other			

In the space below, please provide details about treatments **including Healthcare provider, diagnosis, approximate treatment dates, plan, imaging and lab studies.**

_____

_____

_____

_____

_____

Medications/Supplements

☐ No Medications ☐ No Vitamins/ Supplements

IF NOT ENOUGH SPACE, PLEASE PROVIDE A SEPARATE SHEET

Name	Dosage	Frequency

Allergies

☐ No Known Drug Allergies (NKDA)

For each allergy, please list

1) Name of Allergen
2) The Location and the Reaction
   a. Skin (local rash, rash all over, itchiness, patchy swelling, facial swelling, hives)
   b. Local (runny nose, cough, conjunctivitis/eye inflammation)
   c. Abdominal (pain/cramping, bloating/gas, vomiting, diarrhea, nausea)
   d. Systemic/anaphylactic (shortness of breath, wheezing, tongue swelling, difficulty speaking or swallowing, dizziness/light headedness, loss of consciousness, chest pain, irregular heartbeat, fast heartbeat, slow heartbeat, breathing distress)
3) Severity of the reaction (very mild, mild, moderate, severe)

Food allergy examples: Dairy, egg, wheat/gluten, peanuts, other nuts, shellfish, soy
Environmental allergy examples: dust, pollen, animal dander, dust mites, insect stings, mold, latex.

IF NOT ENOUGH SPACE, PLEASE PROVIDE A SEPARATE SHEET

Allergen **Drug** **Food** **Environmental**	**Location** **Skin** **Local** **Abdomen** **Systemic**	**Reaction** **(See above)**	**Severity** **very mild** **mild** **moderate** **severe**	**Status** **Active** **(A)** **Inactive** **(I)**

Pregnancy & Birth History

Maternal Health During Pregnancy: □ Bleeding □ Trauma □ Hypertension □ Fevers □ Infectious Illnesses □ Medications □ Drugs □ Alcohol □ Smoking □ Rupture of Membranes □ In Vitro Fertilization □ Other _____

Labor & Delivery: Gestational Age at Delivery ____ Duration of Labor _____ Duration of Pushing _____ Delivery Type _____ □ Forceps Used □ Induced □ Epidural □ Breech

Neonatal Period: Birth Weight _____ Length of Stay at Hospital _____
Birth Injuries _____ □ Breathing Problems □ Use of Oxygen □ Need for Intensive Care □ Hyperbilirubinemia/Jaundice □ Feeding Problems

Developmental History

Ages at which milestones were achieved: Smiling _____ Rolling _____
Sitting Alone _____ Crawling _____ Walking _____ Running _____
1st Word _____ Toilet Training _____

School: Day Care (How many days a week?) _____ Present Grade _____ Interactions w/ Peers _____ Interactions w/ Adults _____ List any specific problems _____

Behavior: □ Enuresis □ Temper tantrums □ Thumb sucking □ Pica □ Nightmares
□ Teeth Clenching □ Tics □ Other _____

Feeding History

Breastfed? □Yes □No To what age? _____ **Formula Fed?** □Yes □No To what age? _____

Solids: When were they introduced? _____ List any problems created by the introduction of specific foods: _____

Current Diet (breast-feeding, protein/veggies/carbs/fruits/snack/sugar):_____
_____ **Daily Fluid Intake** _____ **Do you use caffeine**? □Yes □No How much/how often_____ **Do you use artificial sweeteners?** □Yes □No **Fluoride Use** _____

Review of Systems

Please check if you have any of the following:

General: □ Weight gain □ Weight loss □ Change in appetite □ Fatigue □ Weakness □ Sleep disturbance □ Night Sweats □ Irritability □ Indifference □ Fever □ Chills

HEENT: □ Headaches □ Eye pain □ Vision Problems □ Hearing Loss □ Tinnitus □ Ear Pain □ Sore Throat □ Post Nasal Drip □ Nasal Congestion □ Sinus Congestion □ Hoarseness □ Difficulty Swallowing □ Mouth Breathing □ Snoring □ Apnea

Skin: □ Itching □ Burning □ Rashes □ Lumps □ Tumors □ Warts □ Changes in Moles □ Acne

Cardio: □ Cyanosis □ Chest Pain □ Palpitations □ Cold Extremities □ Pain in Extremities □ Foot/Ankle Swelling

Respiratory: □ Wheeze □ Use of Inhaler □ Shortness of Breath w/ Activity □ Shortness of Breath at Rest □ Frequent Cough

Gastrointestinal: □ Nausea □ Vomiting □ Abdominal Pain □ Heartburn □ Change in Bowel Habits □ Reflux □ Diarrhea □ Constipation □ Excessive Gas □ Bloating □ Food Intolerance

Urinary: □ Burning/Pain with Urination □ Flank Pain □ Blood in Urine □ Urinary Frequency/Urgency □ Incontinence □ Difficulty Urinating □ Night time bed wetting

Female: □ Irritability □ Cold Intolerance □ Decreased Energy □ Indecisiveness □ Menstrual Irregularity □ Decreased Flow □ Bloating □ PMS □ Menstrual Cramps □ Frequent Urination □ Excessive Thirst □ Change in Hair Quality □ Easy Bruising □ Delayed or precocious puberty □ Age of First Menstrual Cycle _____

Male: □ Irritability □ Decreased Energy □ Loss of Muscle Mass □ Cold Intolerance □ Excessive Thirst □ Frequent Urination □ Change in Hair Quality □ Easy Bruising □ Delayed or precocious puberty

Musculoskeletal: □ Joint Pain □ Swollen Joints □ Muscle Pain □ Red Joints □ Stiff Joints □ Weakness

Nervous System: □ Headaches □ Numbness □ Tingling □ Radiating Pain □ Seizures □ Tremors □ Loss of Coordination □ Fainting □ Dizziness/Vertigo □ Change in Taste or Smell □ Abnormal Gait □ Poor Memory □ Poor Concentration

Psychological: □ Anxious/Worried □ Anger/Rage □ Hyperactive □ Obsessive/Compulsive □ Depressed Mood □ Feeling Sad or Hopeless □ Poor Focus □ Inability to Concentrate

Add Other Complaints Not Specified Above _____

Social History

Residence (Circle One): Home Independent Home Dependant on Family OTHER _____
I am: □ right-handed □ left-handed **Sleep/rest** (# of hours/quality) _____
Please circle: There are: pets smokers woodstove in the home. **Quality of home life**_____
Physical Activity (type/frequency) _____ **Stretching** (type/frequency) _____
Hobbies/recreation_____

Electronic Use (TV, computer, video games) (How often? # of hours/day &/or days/ week)

_____

Safety measures (seat belt/helmets) _____

Immunizations (Be specific, not just up to date) _____

Immunization Reactions _____

Antibiotic Use in Lifetime _____

Tobacco Use: Do you use tobacco? Yes No Have you ever used tobacco? Yes No

Chew - #/day _____ Pipe - #/day _____ Cigars #/day _____Cigarettes – Pks/day _____

Year started _____ # of Years _____ Year Quit _____

Alcohol Use (Circle One): Never Occasional Moderate Weekly Use Heavy Daily Use

Not Currently # of drinks per week _____

Marijuana Use (Circle One**):** Never Occasional Moderate Weekly Use Heavy Daily Use

Not Currently # of times per week _____

Illicit Drug Use (Circle One): Never Occasional Moderate Weekly Use Heavy Daily Use

Not Currently # of times per week _____ Type of Drug _____

Past Medical History

Please check if you have **ever** had any of the following:

□ Plagiocephaly □ Headache □ Traumatic Brain Injury □ Seizures □ Depression □ Anxiety
□ Strabismus □ Conjunctivitis □ Eye Disease □ Tonsillitis □ Oral Thrush □ Epistaxis (nose bleeds)
□ Otitis Media □ Allergies □ Sinusitis □ Asthma □ Respiratory Disease □ COVID
□ Chronic Bronchitis □ Pneumonia □ Heart Murmur □ Jaundice □ Eczema □ GERD/Reflux
□ Colic □ IBS □ Inflammatory Bowel Disease □ Constipation □ Feeding Problems □ ADD/ADHD
□ Autism □ Sensory Integration Disorder □ Discipline/Behavioral Problems □ Lyme Disease
□Nocturnal enuresis □ PMS/PMDD □ Scoliosis □TMJ Dysfunction □Herniated Disc □Eating Disorder
□ High Blood Pressure □ Angina □ Arrhythmia □ High Cholesterol □ Gastrointestinal Disease
□ Liver Disease, Hepatitis □ Diabetes □ HIV, Infectious Disease □ Thyroid Disease □ Obesity
□ Hiatal Hernia □ Urinary Incontinence □ Kidney Disease □ Substance Abuse □ Cancer □ Anemia
□ Kidney Stones □ Chronic Pain □ Measles □ Mumps □ Rubella □ Varicella □ Pertussis
□ Rheumatic Fever □ Facial Edema □ Vertigo □ Hemoptysis □ PTSD □ Chronic Fatigue
□ Hearing Loss □ Torn Ligaments □ Sprains □ Anatomical Short Leg □ Other:_____

Trauma History

Trauma Type Details and approximate dates **No Trauma History** □

Head Trauma/Concussion:
Motor Vehicle Accidents:

Sports Injuries:
Bone Fractures:
Dental Work (braces, palate expander, etc.):
Birth Trauma:
Emotional Trauma:
Other Trauma:

Past Surgical History

□ None

List surgical history with dates (i.e. circumcision, tongue frenectomy, ear tubes, fracture, etc.):

_____

_____

_____

Family History

Have any blood relatives ever been diagnosed with any of the following? □ Unknown

□ Glaucoma □ Hearing Loss □ Depression □ Alcohol/Substance Abuse □ Arthritis □ Back Pain
□ Heart Disease □ High Cholesterol □ High Blood Pressure □ Stroke □ Seizures □ Diabetes □ Obesity
□ Thyroid Disease □ Osteoporosis □ Autoimmune Disease □ Cancer □ Bleeding Disorder □ Asthma
□ Allergies □ Lyme/Co-infections □ Fibromyalgia /CFIDS □ Scoliosis □ Eating Disorder □ Other_____

	Age	Health Problems	Death/Cause/Age
Father			
Mother			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Siblings			