South Lyon Chiropractic
327 N. Lafayette – South Lyon, MI 48178
Ph: (248) 491.6776

MINOR HISTORY

Today's Date: ___________________________ How did you hear about South Lyon Chiropractic? ____

Has your child consulted a chiropractor before? O No O Yes Whom? _________________ When? _________________ Why? ________________________

CHILD'S INFORMATION

Last Name: ____ First Name: ____ Middle Initial: _____________

Address:____

Street Apt # City State Zip Code

Cell Phone: __(__________)____________________________________ Home Phone: __(__________)______________________________

Age: Years:________ Months:____________ Birth date: _______________________ Sex: ____________ Weight: ___________ Height: ____________

PARENTAL INFORMATION

Last Name: ____ First Name: ____ Middle Initial: _____________

Address:____

Street Apt # City State Zip Code

Cell Phone: __(__________)____________________________________ Home Phone: __(__________)______________________________

Email Address: ____ Age: ___________________ Birth date: ______________________

HEALTH HISTORY

Name of **Pediatrician**: ____ Date of **Last Visit**: ____

When was your child's **last physical exam**? ________________________________ - Normal? O No O Yes

Has a physician treated your child for any **health condition** in the past year? O No O Yes - Please explain: ____

Is this visit due to an **accident**, **injury** or **trauma**? O No O Yes - If so, was it: O Auto O Work - Please Explain:_____________________________________

List any **accidents**, **injuries** or **traumas** your child has experienced: ____

List any **surgeries** or major **illnesses**: ____

Has your child been **injured participating in contact sports**? □ NO □ YES: If so, please describe: ____

Has your child ever been **involved in a car accident**? □ NO □ YES: If so, please list date & injuries: ____

List any major **allergies**: ____

Has your child ever been to an **emergency room**? O No O Yes – explain: ____

Has your child ever been **admitted** to a **hospital**? O No O Yes – explain: ____

Diagnostic Imaging: O X-Ray O MRI O CAT Scan

When? ______________________ Where? __________________________________ Why: ____

Does your child have any **implanted medical devices** or **imbedded foreign objects**? O No O Yes - ____

Has your child ever been fitted for a special **brace**, worn a **brace** or worn a **cast**? O No O Yes - ____

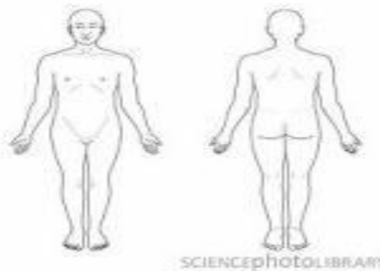
Is your child in good **overall health**? O No O Yes **FEMALES**: Do you see a gynecologist regularly? O No O Yes

CURRENT COMPLAINT

Reason for seeking chiropractic care: ___________________________________**Onset** (When did you first notice the current symptom(s)): ___________________

Location of pain or complaint: ____

Mark the area(s) of complaint on the picture



Intensity: (How extreme are the current symptoms?) 0 O—O—O—O—O—O—O—O—O—O—O 10

Absent Uncomfortable Agonizing

Duration and Timing: (When did it start & how often does your child feel it?) O Constant O Comes & Goes How Often? _______

Feels Like: O Numbness O Tingling O Stiffness O Dull O Aching O Cramps O Nagging O Sharp O Burning O Shooting O Throbbing O Stabbing

Radiation (What areas does the pain go?):____

What tends to **worsen** this problem? ____

What tends to **lessen** the problem? ____

Other Doctors seen for this condition: ____

Prior Treatment and outcome: ____

Other health problems: ____

FILL OUT BELOW IF CHILD IS 10 OR YOUNGER

PRENATAL HISTORY

Location of Birth: ☐ Home ☐ Birthing Center ☐ Hospital ☐ Stepchild ☐ Adopted

Complications during pregnancy or labor? ☐ N ☐ Y: ____

Medications during pregnancy: ____

Cigarette / alcohol use during pregnancy? ☐ N ☐ Y: ____

Birth Intervention: ☐ Forceps ☐ Vacum ☐ Caesarian, Why? ____

Complications during delivery: ____

Genetic disorders or disabilities? ☐ N ☐ Y: ____

Birth weight: _______________________ Birth Length: ___________________ APGAR scores: 1min _________ 5min ________

FEEDING HISTORY

Breast Fed: ☐ N ☐ Y: How Long? _________________________________ Formula Fed: ☐ N ☐ Y: How long? ____________________

Colic: ☐ N ☐ Y: If so, how long has this been occurring? _________________ How long does a session last? __________________

DEVELOPMENTAL HISTORY

Sleep (hr per night):__________________ Naps (# & length): ______________________ Problems Sleeping? ☐ N ☐ Y: __________________________

At what age was your child able to: Crawl: _________ Sit Alone: _________ Stand Alone: __________ Walk Alone: __________ Say Words: _________

CHILDHOOD DISEASES

☐ Chicken Pox – Age: _______ ☐ Mumps – Age: _______ ☐ Rubela – Age: _______ ☐ Whooping Cough – Age: _______

☐ Measels – Age: _______ ☐ Meningitis – Age: _______ ☐ Tuberculosis – Age: _______ ☐ Other – Age: _________________

____

Signature – Patient or Personal Representative or Parent/Guardian **Date**