

Practice Member Profile

(newborn-12 years)

Last Name _____ First Name _____
Address _____ City _____ State _____ Zip _____
DOB _____ Age _____ SSN# _____
Home Phone _____ Cell Phone _____
Mother _____ Father _____
Email (Parent's) _____ May we send you office newsletters? Yes No
Who may we thank for your referral to our office? _____
Has your child ever received chiropractic care? Yes No
If so, when was their last visit? _____

List all drugs your child is taking (including prescription and non-prescription drugs, such as asthma medication, Tylenol, cold tablets, and allergy medicine)

Medication _____	Purpose _____
Medication _____	Purpose _____
Medication _____	Purpose _____
Medication _____	Purpose _____

Does your child take any Vitamins or Herbs? Yes No Prescribed by: _____

Does your child drink filtered/bottled water? Yes No

Children (only newborns - 6 years old)

Birth:

Forceps used Vacuum Extraction Cesarean Section(planned: YES/NO)

Were there complications during delivery? No Yes,

Were you given an epidural? Yes No

Birth Weight _____ Birth Length _____

Breast fed: No Yes, how long? _____

Formula fed: No Yes, how long? _____

Introduced to Solids at: _____ Months Cow's milk at: _____ Months

Food / Juice Allergies or Intolerances

When was your child's most recent fall? _____ What happened?

Which high impact, or contact type sports, is your child involved (such as Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? _____

Has your child ever been involved in a car accident? No Yes, (dates/any treatment) _____

Has your child ever been seen on an emergency basis? No

Yes (please list all) _____

Which of the below conditions has your child experienced? Mark all those that your child is currently experiencing with a star.

- | | | |
|---|--|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Dislocated Joints | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Aids | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> German Measles | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Bone Fracture | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Bowel Control Loss | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Serious Injury |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Tired/Fatigued |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> V.D. |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Other |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Multiple Dystrophy | |

Which of the above conditions do you expect to be helped with chiropractic care?

Has your child been vaccinated? No Yes, which ones?

When was the last vaccination? _____ Which vaccination was it? _____

Childhood Diseases:

- | | | | |
|--------------------------------------|--------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rubella | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Rubeola | <input type="checkbox"/> Other _____ | | |

I understand that I may be contacted by phone.

Consent for treatment for minor:

I hereby authorize Dr. Jason T. Redler and whomever he may designate as assistants to administer examination and chiropractic care as deemed necessary to:

Name of child

Signature of parent or guardian

Date