

General Information: Infant/Child Form



Child's Name _____

Birth Date ___/___/___

Parent(s) Name(s) _____

Today's Date ___/___/___

Address _____ City _____

State _____ Zip Code _____ E-Mail _____

Home # _____ Work # _____ Cellular # _____

Please indicate the best phone number to contact you: Home ___ Work ___ Cellular ___

Age of child _____ Names and ages of other children (if any): _____

How did you find us? Whom may we thank for referring your child? _____

If your child has health insurance: Policy Holder Name and Birthday _____

Health Profile

What is the reason your child is seeking services here? _____

Please list any other health concerns your child may be experiencing. _____

What changes in your child's health or behavior would you like to see? _____

Has your child had any surgery, hospitalizations, or diagnoses we should know about? _____

Please briefly describe your child's food and fluid intake. Any vitamins/supplements? _____

Please list any prescription or over-the-counter drugs your child is using or has used recently. _____

Pregnancy and Labor of Your Child

Was there any assistance needed during birth?

Forceps

Cesarean

Vacuum extraction

Were there complications during the pregnancy and/or birth? Yes No Please explain:

Was there any evidence of birth trauma to the infant?

Bruising

Odd shaped head

Stuck in birth canal

Very long birth

Respiratory depression

Cord around neck

Growth and Development

Any traumas resulting in bruises, fractures, stitches? Yes No _____

Was/is child breast fed? Yes No For how long? _____

Do you consider their sleeping pattern normal? Yes No _____

Behavioral or social problems? Yes No _____

Is school backpack used? Yes No (Heavy / Light)

Has your child experienced any of the following?

vision problems

pink eye

constipation

headaches

ear problems

asthma

sleeping difficulty

tubes in the ears

colic

irritability

attention problems

allergies _____

skin problems

frequent colds

bedwetting

breathing problems

digestive problems

hyperactivity

other _____

Average number of hours your child watches television, plays on the computer, or plays electronic games each week, if any?

Any sports participation or other hobbies/activities? _____

Thrive Chiropractic Center – Care Agreement

Please read the following statements to acknowledge that you understand our services and objectives.

- Thrive Chiropractic Center exists to make a positive contribution in the lives of people, by assisting them to express and experience more health and vitality in their bodies and in their lives.
- Chiropractic is a science and healing art focused on the relationship between structure, primarily of the spine, and function, primarily of the nervous system.
- The nerve system is used for the transfer of vital information essential for all human works—from bodily functions to emotions, creativity, performance, perception and expression. The nerve system is our link between the inner and outer world and consists of the brain, spinal cord, nerves, and neurotransmitters. All cells of the body are regulated through the nerve system.
- The function of the nervous system affects the health of the body. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.
- A misalignment of structures in the spine can cause changes in nerve function and interference in the communication system within the body. This condition results in a lessening of the body's innate ability to express its maximum health potential.
- The chiropractic adjustment is a specific application of forces, by hand or instrument, to correct misalignments. The adjustment can help restore and enhance the full function and communication within your body, from the brain to every organ, tissue and cell.
- The primary objective of Thrive Chiropractic Center is to help people achieve greater levels of well-being, independent of any symptom(s) or condition(s) they may or may not be experiencing. We practice the art of living well. If you become concerned about symptoms or conditions, we suggest you seek the care of a medical professional who specializes in the diagnosis and treatment of disease and symptoms.
- I understand my right to be informed about the condition of my health and the care options available and that it is my choice to accept or decline chiropractic care.
- I understand that I am responsible for payment at the time services are rendered.

I have read and understand the above statements. I choose for myself, and any family members under 18 years old listed below, to be served at Thrive Chiropractic Center in accordance with the above care agreement.

PRINT NAME

SIGN NAME

DATE

PRINTED NAMES OF MINOR CHILDREN TO RECEIVE CARE