



**KEHOE FAMILY
CHIROPRACTIC, LLC**
(727) 859-9700
www.kehoechiro.com

*Raise a healthy child with
Gonstead Chiropractic Care.*

Dear Parent:

Please complete this questionnaire. Your answers will help us determine if chiropractic can help your child. If we do not sincerely believe your child's health will benefit, we will not accept your child's as a patient. Thank you.

Child's Name: _____ AGE: _____ Date of Birth: _____
 Address: _____ City: _____ State: _____ ZIP: _____
 Parent's/Guardian Name: _____ Home # _____
 Email: _____ Cell# _____
 Parent's DOB _____

Health History

Did you have any complications during pregnancy? no yes IF yes, Please describe: _____

DELIVERY: No Complications Vaginal Forceps/ vacuum Breech Cesarean
 LOCATION: Home Birthing Center Hospital Doula Mid-wife
 Name of OBSTETRICIAN/MID-WIFE: _____
 BIRTH WEIGHT: _____ BIRTH LENGTH: _____
 APGAR SCORE: _____ Presence of: Jaundice Cyanosis (blue)

INFANTILE FEEDING: Breast How long? _____ Bottle Formula

CONGENITAL ABNORMALITIES: _____

Date of last medical visit: _____ Purpose: _____

IMMUNIZATION HISTORY: Never received shots Received shots (please list) _____

Noticed any complications/difficulties/reactions after shots? no yes yes * If Yes or unsure please describe: _____

Has your child ever been treated on an emergency basis? no yes (describe) _____

Does your child drink milk? no yes If yes, How much? _____ / day

What type of milk? Organic Whole milk 2% 1% skim OTHER: _____

Has your child ever been on antibiotics? no Yes How many times? _____

Has your child recently been or currently on any medications including over the counter medication? Yes No Please list: _____

Has your child suffered from: Colic Ear Infection Asthma Recurrent Colds
 Chronic Cough Chronic Runny nose Constipation

Has your child been in an auto accident, even minor "Fender Bender" Yes No
 If yes Please Describe: _____

Current Condition

Is your child here for: Wellness Checkup Specific Condition

Please Explain: _____

How long has your child had this condition? _____ Is this the first time? yes no

What activities aggravate their condition? _____

Does their condition seem to be getting worse? Yes No

Who else has your child seen for this condition: _____ When? _____

What reaction has your child had to past treatments for this? _____

Has your child ever had a chiropractic check-up before? yes no When? _____