KehoeFamily Chiropractic

It is never too early.

A small adjustment now, can make a world of a difference in your child's growth and development.

Welcome to our office. Help us get to know your child.

Child's Name:	**Preferred Name:**
Name of Parents (Guardians):	**Relationship:**
Address: City State Zip	
Child's Date of Birth:	**Parent's Email Address:**
Parent's Phone Number:	**Home or Cell**
How would you like to receive complimentary appointment reminders? TEXT EMAIL CALL None Needed **If text is requested, what company do you use as your cell phone carrier?**	

Health History

Child's birth weight?	**Child's birth length?**	**APGAR SCORE**
Did you have any complications during your pregnancy or birth?		
Birth details. Please circle all that apply. HOMEBIRTH HOSPITAL BIRTH BIRTHING CENTER DOULA MIDWIFE C-SECTION UN-MEDICATED VAGINAL BIRTH BREECH FORCEPS/VACUUM EPIDURAL		
Was your child breast fed? YES NO How long? If no, what formula did your child drink?		
Has your child been vaccinated? YES NO If yes, which vaccines have been administered?		
Has your child ever had any adverse reactions to a vaccine? YES NO NOT SURE **If yes, please explain?**		
How often does your child have a bowel movement?		
How much time does your child spend outdoors on most days? < 1hr 2-3 hrs 3+hrs		
Has your child ever been on antibiotics? YES NO If yes, how many times?		
Please describe your child's sleeping habits. (length, naps…)		
If applicable, please specify at which age your child met these developmental milestones. **ROLLING OVER _____ CRAWLING _____ WALKING _____ TALKING _____**		

Medications (include over the counter)	For what reason	For How Long
Vitamins/Supplements/Herbs	**For what reason**	**For How Long**

Healthcare History

Healthcare practitioners your child has seen in the last year			
Name	**City**	**Last Visit**	**Reason for your visit**

List ALL Surgeries/Hospitalizations/Accidents/Stitches/Broken Bones		
Type	**Date**	**Recovery outcome?**

Below is a list of symptoms. Please check if your child has had or is currently suffering from any of the following:

Past	Symptom	Present
	colic	
	cradle cap	
	vomiting	
	breathing troubles	
	coughing	
	allergies	
	diarrhea	
	pink eye	
	behavioral problems	

Past	Symptom	Present
	constipation	
	toe(s) point in/out	
	fever	
	diaper rash	
	ear infection	
	poor appetite	
	hip dysplasia	
	pin worms	
	toe walking	

Past	Symptom	Present
	eczema	
	rashes	
	trouble talking	
	delayed potty training	
	sinus issues	
	chronic runny nose	
	abdominal pain	
	flu	
	bed wetting	

CURRENT CONDITION

Reason for your child's visit today? Wellness/Developmental Support OTHER ? Specify:	
How long has this affected them? _____ Days _____ Months _____Years	
Has your child been under chiropractic care before? YES NO	**How long ago? If yes, was it for this condition? YES NO**
Has your child seen anyone else for this ? YES NO	**Who?**
Was the outcome helpful? YES NO UNSURE	**When was your last visit?**
What else have you done for this?	
What makes your child's situation better?	**What make their situation worse?**
Is your child's condition getting better or worse over time?	
Is there anything else we should know?	