

SILVER VIEW CHIROPRACTIC CENTER, P.A.
5372 Edgewood Drive - Mounds View, Minnesota 55112 763-786-5581

• **About the Child**

Name: _____ Birthdate: _____ Age: _____

Gender: _____ Weight: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Has the child ever seen a Chiropractor before? _____

• **About the Parent**

Name: _____ Birth Date: _____ Age: _____

Address: (*Same as above*) _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Insurance Company: _____ Insured's Name: _____

Have you ever seen a Chiropractor before? _____

• **Reason for Visit**

Describe reason for this visit: _____

Visit related to: **A Fall** **Sports Injury** **Auto Accident** **Other** _____

Please explain: _____

When did the condition begin: _____

Has the condition been: **Staying the same** **Getting worse** **Getting better**

Have you seen a doctor for this condition? _____

- **Mother's Pregnancy and Labor**

During your pregnancy, did you use:

Drugs Tobacco Medications Alcohol NA Please describe: _____

Describe your delivery: _____ Please Explain: _____

Yes or **No** Labor was chemically induced

Yes or **No** C-section delivery

Yes or **No** Forceps or vacuum extraction

Yes or **No** Did you experience any illness when pregnant?

Yes or **No** Did you nurse your baby?

Yes or **No** Did the baby have colic?

Yes or **No** Did you choose to vaccinate your child?

- **Child's Health History**

Please check all that apply or have applied to your child:

Allergies

Earaches

Tubes in Ears

Asthma

Frequent Colds

Irritability

ADHD

Ear Problems

Other:

Bed Wetting

Digestive Problems

Breathing problems

Constipation

Colic

Sleeping Disorders

Headaches

Vision Problems

Is your child currently taking any medications? _____

Has your child ever been on antibiotics? _____

Pediatric Functional Form

Today's Date _____ Child's Name _____

Form filled out by _____

Please check all that apply to your child

- ____ 1. Has your child been more irritable?
- ____ 2. Has your child had difficulty sleeping?
- ____ 3. Has your child's sleeping patterns changed?
- ____ 4. Has your child's digestion pattern changed? (i.e. constipation/diarrhea)
- ____ 5. Has your child's intake of food been less or more?
- ____ 6. Has your child needed more parental attention/affection?
- ____ 7. Has your child been more distant/less affectionate?
- ____ 8. Has your child had trouble with learning or retaining information?
- ____ 9. Has your child's attention or focus been shortened?
- ____ 10. Has your child's balance or coordination been altered?
- ____ 11. Have you noticed any changes in speech patterns?
- ____ 12. Have you noticed any changes in breathing patterns?
- ____ 13. Have you noticed any visional changes such as squinting?
- ____ 14. Have you noticed a change in "playing" patterns?
- ____ 15. Have you noticed any aggression/violence/acting out?
- ____ 16. Have you noticed any changes in relationships with grandparents/daycare providers/teachers?