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?