TRULL CHIROPRACTIC, P.A. 1739 Dale Earnhardt Blvd, Kannapolis, NC 28083 (704) 938-1141

Date: _____

First name: _____ Middle name: _____

Maiden name: _____ Last name: _____

Suffix: _____ Name you wish to go by: _____

Address: _____

City: _____ State: _____ Zip code: _____

Birthdate: _____/_____/_____

Sex: ❑ Male ❑ Female

How did you hear about us? _____ Who referred you? _____

Mother's Full Name: _____ Birth date: _____

Address (if different from above): _____

Cell Phone: _____ Home Phone: _____ Is the child's mother a patient? ❑ Yes ❑ No

Father's Full Name: _____ Birth date: _____

Address (if different from above): _____

Cell Phone: _____ Home Phone: _____ Is the child's father a patient? ❑ Yes ❑ No

Marital status of parents: _____ Child lives with/custody: _____

Any family or custody circumstances that we should be aware of: _____

Name(s) of step-parents, if any: _____

Emergency contact's full name: _____

Relationship: _____ Phone number: _____

I hereby grant permission for my child to receive chiropractic evaluation and treatment. I also accept full responsibility for the charges incurred during his/her course of treatment. In the event I (or the child's other parent or legal guardian) am unable to accompany my child on a future visit, I grant the following person(s) to bring my son/daughter in for treatment:

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Signature: _____ Relationship to child: _____

Date: _____ Witnessed: _____

PLEASE FILL OUT BOTH SIDES COMPLETELY.

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MEDICAL HISTORY

Purpose for today's visit: _____

List any health problems: _____

Name of Pediatrician: _____ Date of last visit: _____

During the following times, your child is susceptible to spinal subluxations (nerve interference). List the age at which your child began to: roll over: _____ lift head: _____ sit up: _____ crawl: _____ stand: _____ walk: _____

The National Safety Council estimates 50% of children fall from a high place during his/her first year of life.

Estimated times your child has fallen in his/her first year: _____

Involved in a motor vehicle accident? ❑ yes ❑ no If yes, when? _____

Involved in high impact sports? ❑ yes ❑ no If yes, list sports: _____

List all childhood diseases (i.e. diabetes, cancer, autism, etc.): _____

List all surgeries: _____

List all fractures: _____

List all medications: _____

List all known allergies to medications: _____

Number of doses of antibiotics child has taken during past 6 months: _____ lifetime: _____

Number of doses of other drugs: _____ Vaccinations: _____

PRENATAL HISTORY

OB/GYN: _____ Midwife: _____

Complications during pregnancy? ❑ yes ❑ no If yes, please list: _____

Complications during delivery? ❑ yes ❑ no If yes, please list: _____

Drug use during pregnancy? ❑ yes ❑ no alcohol use? ❑ yes ❑ no tobacco use? ❑ yes ❑ no

FEEDING HISTORY

Breast feed? ❑ yes ❑ no How long? _____ Formula? ❑ yes ❑ no How long? _____

What age was your child introduced to: solid food? _____ cow's milk? _____

Allergies or intolerance to food? ❑ yes ❑ no If yes, please list: _____

How many glasses per day of: tea? _____ soft drinks? _____ water? _____ juice? _____

Signature of Parent/guardian: _____

Printed name of person above: _____

TO BE PERFORMED BY CLINIC STAFF: **HT** _____inches **WT** _____pounds **BP** _____ / _____ R / L

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