Sailer Family Chiropractic

Date: / /

Personal Information (Please print):

Name _____ Prefer to be called _____
First MI Last
Address _____ City _____ State _____ Zip _____

Home#_____ Date of Birth _____/_____/_____ Age _____ □ Male □ Female

Mothers Name _____ Cell # _____Work#_____

Fathers Name _____ Cell # _____Work#_____

E-mail Address _____

Insurance Information:

Health Insurance _____ ID Number _____

Group # _____ Name of Insured _____ DOB _____

Relationship to Insured: □ Self □ Spouse □ Child □ Other_____

Who can we thank for referring you to us? _____
Please select one: □ YellowBook □ SmartSearch □ Dex □ Internet(Google) □ Other_____

Mainly for Moms:

Tell us about your pregnancy;
How many weeks along at time of delivery? _____
Describe any complications and when they occurred: _____

Tell us about your delivery and birth of this child:

Type of Birth: □ Normal Vaginal □ Cesarean □ Vacuum Extraction □ Forceps

Medications: □ Induction □ Epidural

Describe any complications and when they occurred: _____

Tell us more:
Did you breastfeed? □ Yes □ No If yes, how long? _____ What formula after? _____
Did you consume alcohol during your pregnancy? □ Yes □ No Did you smoke? □ Yes □ No
Did you take any medication during your pregnancy? □ Yes □ No If yes, For what? _____
Any exposures to ultrasound? □ Yes □ No If yes, How many?_____
Did baby receive vaccinations? □ Yes □ No

Tell us about any vaccinations your child has had: _____
_____

Any reactions to any of these? _____
Were you told that you had a choice in vaccinating your child? □ **Yes** □ **No**
Would you like information on the 'other side' of this issue? □ **Yes** □ **No**

List any Medications your child is currently taking:_____
Describe any hospital stays:_____
Has antibiotics been prescribed? □ **Yes** □ **No**
If yes, approximately how many times? _____ For what conditions?_____

As a baby/toddler, (birth to 4 years), did any of the following occur?

□ Fall from a change table	□ Fall off playground equipment	□ Frequent crying spells
□ Tumble down stairs	□ Frequent fevers	□ Fall out of crib
□ Frequent bouts of diarrhea	□ Involved in car accident	□ Constipation
□ Sleeping problems	□ Play in Jolly Jumper	□ Frequent colds
□ Frequent ear infections	□ Colic	□ Tonsillitis
□ Did not gain weight	□ Reaction to vaccination	□ Other_____

Please explain the above: _____

As a young child, (5-12 years), did any of the following occur?

□ Fall from a tree	□ Bed wetting
□ Fall off a bicycle	□ Hyperactivity/Autism
□ Fall off playground equipment	□ Learning difficulties
□ Sports accident	□ Asthma
□ Car accident	□ Allergies
□ Stomach pains	□ Leg/knee pains
□ Scoliosis	□ Other_____

Please explain the above: _____

As a child or adolescent, has your child experienced any of the following:

□ Headaches	□ Numbness in arms/hands	□ Foot/ankle/knee pains
□ Dizziness	□ Arm/wrist pains	□ Tingling in arms/legs
□ Ringing in ears	□ Sleeping problems	□ Neck/back pains
□ Asthma	□ Allergies	□ Shoulder pains
□ Hyperactivity	□ Stomach problems	□ Growing Pains
□ Fatigue	□ Weight gain/loss	□ Other _____

Please explain any of the above: _____

Patient History:

Please list your major complaints:	How long?	Is it getting (B) better (W) Worse or (S) Same?	Constant or Reoccurring?
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____

Did it occur from a motor vehicle accident? □ Yes □ No If yes, Did you report the incident? □ Yes □ No

What *aggravates* their condition? □ Sitting □ Standing □ Bending □ Lifting □ Sleeping □ Other_____

What *decreases* their condition? □ Sitting □ Standing □ Bending □ Lifting □ Sleeping □ Other_____

Does it cause your child pain to cough, grunt, or sneeze? □ **Yes** □ **No**

If yes, where? _____

Has your child seen a doctor for this condition? □ **Yes** □ **No**

If yes, □ MD □ Physical Therapist □ Chiropractor □ Athletic Trainer □ Other_____

Does this condition affect your child's sleep? □ **Yes** □ **No**

In what position does your child sleep? □ Back □ Stomach □ Side legs together □ Side with top leg higher

What percentage of the day does your child have pain? □ 0-25% □ 26-50% □ 51-75% □ 76-100%

What is the pain level, on a scale of 0-10? 1 2 3 4 5 6 7 8 9 10