Living Well Holistic Health, LLC

PEDIATRIC REGISTRATION & HISTORY

Child's Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

1st Parent's Name:_____ Work Phone:_____

2nd Parent's Name:_____ Work Phone:_____

Would you like our free monthly Wellness Newsletter by email? Y / N Email:_____

Birth date:_____ Age:_____ Sex: M / F Number of siblings:_____

Birth Weight:_____ Current Weight:_____

Birth Length:_____ Current Length:_____

Type of birth (check all that apply) [ ] Normal Vaginal [ ] Forceps [ ] Vacuum

[ ] Breech [ ] C-section [ ] Home

[ ] Birth Center (name)_____

[ ] Hospital (name)_____

Problems during pregnancy:_____

Problems during labor delivery:_____

APGAR Scores:_____ At birth, was there a presence of: Jaundice (yellow)

Cyanosis (blue)

Congenital anomalies/defects:_____

Infant Feeding - Please list at what age the child received each method.

Breast _____ Bottle_____ Formula _____

Number hours sleep per night:_____ Quality of sleep: Good / Fair / Poor Explain:_____

Obstetrician/Midwife:_____

Pediatrician:_____

Date of last visit to MD:_____ Purpose:_____

Immunization History:_____

Has your child ever been treated on an emergency basis? Y / N Explain:_____

Purpose of today's appointment:_____

Whom may we thank for referring you to our office?_____

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PEDIATRIC REGISTRATION & HISTORY

PERSONAL HEALTH HISTORY Has this child ever suffered from:

[ ] Dizziness	[ ] Backaches	[ ] Heart trouble	[ ] Diabetes
[ ] Tuberculosis	[ ] Colds/Flu	[ ] High blood pressure	[ ] Arthritis
[ ] Headaches	[ ] Asthma	[ ] Neuritis	[ ] Colic
[ ] Digestive trouble	[ ] Sinus trouble	[ ] Constipation	[ ] Bed-wetting
[ ] Anemia	[ ] Rheumatic Fever	[ ] Orthopedic	[ ] Diarrhea
[ ] Poor appetite	[ ] Hyperactivity	[ ] Sugar concentration	[ ] Behavioral problem
[ ] Convulsions	[ ] Paralysis	[ ] Muscle jerking	[ ] Fainting
[ ] Walking problems	[ ] Broken Bones	[ ] Ruptures/Hernia	[ ] Neck problems
[ ] Arm problems	[ ] Leg Problems	[ ] "Growing Pains"	[ ] Chronic Ear Infections
[ ] Blood disorders	[ ] Stomach Aches	[ ] Joint problems	

Surgeries: _____

Medications (name & purpose): _____

Allergies: _____

FAMILY HEALTH HISTORY

Please place a check mark if someone in the child's immediate family has had the following.
Please write how they are related to the child.

[ ] Back Problems _____	[ ] Headaches _____
[ ] High pressure _____	[ ] Ulcer/Digestive Problem _____
[ ] Thyroid Disorder _____	[ ] Heart Disease _____
[ ] Stroke _____	[ ] Arthritis _____
[ ] Diabetes _____	[ ] Cancer _____
[ ] Osteoporosis _____	[ ] Mental Illness _____

WELLNESS PROFILE

Chiropractic care affects more than just our muscles and bones. Please share with us what health goals you hope to find for this child. Check as many boxes as you wish

[ ] More energy	[ ] Better sleep	[ ] Freedom from pain
[ ] Better concentration	[ ] Easier breathing	[ ] More balanced posture
[ ] Try quality vitamins	[ ] Improve nutrition	[ ] Improved coordination
[ ] Reduce medications	[ ] Improve overall health	[ ] Better sports performance
[ ] Enhanced emotional well-being	[ ] Greater resistance to disease	[ ] Other