



CHILD INFORMATION

6237A Sunset Drive, Miami FL, 33143

DATE / /

NAME _____ BIRTH DATE _____
 AGE _____ SEX (M / F) _____ HEIGHT _____ WEIGHT _____
 SS# _____

Names of Parents / Guardians _____

Number of Children _____ Ages of Children _____

Home Phone _____ Work Phone _____

Address _____

City/State/Zip _____

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

PURPOSE FOR CONTACTING US? _____

Other doctors seen for this condition: _____

Please Check the Health Complaints your Child is Currently Experiencing
 or Experiencing on a Recurring Basis:

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Ear Infection |
| <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Allergies | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Car Accident | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Traumas / Injuries |
| <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Colic | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> ADHD / ADD | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Growing / Back Pains |

Other _____

Please comment on how often any of the above have occurred and when they occurred. _____

MEDICATIONS

Number of doses of ANTIBIOTICS your child has taken:

During the past 6 months: _____

Total in his / her lifetime: _____

Please list the types of PRESCRIPTION or NON-PRESCRIPTION drugs your child has taken:

VACCINATION HISTORY: _____

List any SURGERIES or CONGENITAL CONDITIONS: _____

Has your child been seen on an emergency basis? yes no List: _____

PRENATAL & BIRTH HISTORY

Complications during pregnancy or delivery? yes no Explain: _____

Medications during pregnancy or delivery? yes no List: _____

Ultrasounds during pregnancy? yes no number _____

Location of birth: Hospital Birthing Center Home

Birth Intervention: Forceps Vacuum Extraction
 Caesarian Section, Emergency or Planned?

DIET HISTORY

Breast Fed: yes no How long? _____

Appetite / Feeding problems? yes no List: _____

Allergies or Intolerances: _____

SOCIAL HISTORY

Is / has your child been involved in any high impact or contact type sports (i.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? yes no

List: _____

Has your child shown any unexplained changes in behavior or performance at school or home?
 yes no

***WE ARE HERE TO SERVE YOU & ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL & WILL HELP DETERMINE YOUR RESULTS.***

Please supply our office with your insurance card for your child's patient file.

I assign my insurance benefits to Bailey Chiropractic Life Center. I also understand that all services rendered to my child are charged to me and I am responsible for payment unless other arrangements are made.

I hereby authorize this office & its doctors to administer care to my child.

Parent Name: (Please Print) _____

Parent Signature: _____ Date: _____