



Lark Chiropractic

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to create better health for your family.

(Please Print)

Patient Name: _____

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

Home Phone: (____) _____ Cell: (____) _____ Work: (____) _____

Date of Birth: ____/____/____ S.S.# ____ - ____ - ____ Gender: Female Male Height: _____ Weight: _____

Parent(s)/Guardian Name(s): _____ Referred By: _____

Purpose for Contacting Us? _____

Have Other Doctors Been Seen for this Condition? Yes No If Yes, List Doctor Name(s) and Prior Treatments:

Any Other Health Problems? _____

Check Any of the Following Conditions Your Child Has Experienced During the Past Six Months:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Asthma / Allergies | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Growing / Back Pains |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Seizures | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Other: _____ |

Family History: _____

Previous Chiropractor (If Any): _____ Date of Last Visit: _____

Reason: _____

Are You Satisfied with the Care Your Child has Received There: Yes No

Name of Pediatrician: _____ Date of Last Visit: _____

Reason: _____

Are You Satisfied with the Care Your Child has Received There: Yes No

of Antibiotics Your Child has Taken During the Past Six Months: _____ During His/Her Lifetime: _____

of Doses of Other Prescription Medications Your Child has taken: During the Past Six Months: _____

During His/Her Lifetime: _____ Please List: _____

Vaccination History: _____

Prenatal History:

Name of Obstetrician/Midwife: _____

Complications During Pregnancy: Yes No List: _____

Ultrasounds During Pregnancy: Yes No Number: _____

Medications During Pregnancy/Delivery: Yes No List: _____
Cigarette/Alcohol Use During Pregnancy: Yes No
Location of Birth: Hospital Birthing Center Home
Birth Intervention: Forceps Vacuum Extraction Caesarian Section If C-Section: Emergency Planned
Complications During Delivery: Yes No List: _____
Genetic Disorders or Disabilities: Yes No List: _____
Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

Feeding History:

Breast Fed: Yes No How Long? _____
Formula Fed: Yes No How Long? _____ What Type? _____
Introduced to Solids at _____ Months Introduced to Cows' Milk at _____ Months
Food/Juice Allergies or Sensitivities: Yes No List: _____

Developmental History:

During the following developmental stages your child's spine is most vulnerable to stresses and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

Sit Up: _____ Stand Alone: _____ Hold Head Up: _____ Walk Alone: _____
Cross Crawl: _____ Respond to Sound: _____ Respond to Visual Stimuli: _____

According to the National Safety Council, approximately 50% of children fall head-first from a high place during their first year of life (for example: a bed, changing table, stairs, etc.). Has your child had a head-first fall? Yes No

Is/has your child been involved in any high impact or contact sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? Yes No List: _____

Has Your Child Ever Been Involved in a Car Accident? Yes No List: _____

Has Your Child Been Seen on an Emergency Basis? Yes No List: _____

Other Traumas Not Described Above? Yes No List: _____

Prior Surgery: Yes No List: _____

Menarche : Yes No Age: _____

Childhood Diseases: Please mark all that apply.

Chicken Pox Age: _____ Mumps Age: _____
 Rubella Age: _____ Whooping Cough Age: _____
 Rubeola Age: _____ Other(s) List: _____

Authorization for Care of Minor

I hereby authorize this office and its Doctors and Staff to administer Chiropractic care to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees at the time services are rendered.

Name of Parent/Guardian: _____ Date: _____

Signature of Parent/Guardian: _____