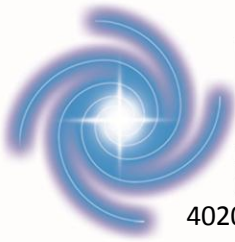

INNATE
FAMILY CHIROPRACTIC
4020 Baltimore Ave. Kansas City, MO 64111

Patient Information

Patient Name: _____ Date: _____

DOB: _____ Age: _____ Sex: ____ Male ____ Female

Address: _____

City: _____ State: _____ Zip: _____

Home Number: _____ Cell Number: _____

Office Number: _____

Where do you prefer to receive calls? ____Home ____Office ____Cell ____No Preference

Whom may we thank for referring you to us? _____

Responsible Party

Name of Person Responsible for Account _____

Relationship to Patient _____ Phone _____

Address _____City _____

State _____ Zip _____

Name of Employer _____ Work Number _____

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Parent, Guardian or Personal Representative Date

_____ _____
Print Name of Parent, Guardian or Personal Representative Relationship to patient

Present Health Challenge(s)

For what health challenge(s) is your child here for?

_____

What do you feel is the cause of your child's problem?

_____

When did you first notice this sign of body dysfunction?

_____

Is this dysfunction getting progressively worse? ___Yes ___No
If yes, why do you think so?

_____
_____
_____

What are the most significant measures you have taken to date to improve your child's present health challenge? Please list all the healthcare practitioner's seen, treatments rendered, and any results experienced.

_____
_____
_____
_____

Please list the (3) most significant stressful events in your child's life from the most recent to the most distant. Are any of these situations continuing to impact his/her life? If yes, please explain clearly.

_____
_____
_____
_____

Please list any and all other concerns regarding your child's health and whether or not you feel they are related to your child's primary reason for being seen in our office today.

_____
_____
_____

___Allergies	___Frequent colds/ Congestion	___Upper respiratory Infections	___Asthma
___Ear infections	___Infected/Sore Throat	___Tonsillitis	___Laryngitis
___Colic	___Reflux/spitting up	___U-tract infections	___Poor appetite
___Poor digestion/ (constipation/diarrhea)	___Thrush mouth/ Chronic diaper rash	___Eczema/psoriasis/ Other skin rashes	___ADD/ADHD
___Irregular sleep Patterns	___Night terrors	___Bed wetting	___Headache
___Anxiety	___Mood wings	___Bruising	

Did you know that the persistent use of antibiotics can lead to an early onset of gastrointestinal tract distress leading to overgrowth of intestinal yeast? Did you also know that chronic use of antibiotics can lead to antibiotic resistant bacteria? Please list any and all prescription medications that your child is presently using and had used on more than one occasion. Please reflect carefully as your child's present health state may be related directly or indirectly to the treatment of a past problem.

_____
_____
_____
_____

Each year a growing number of children are hospitalized due to acetaminophen and ibuprofen poisoning. Has your child taken any of these products that contain these chemicals? ____ Yes ____ No
If yes, for what reason and for how long? _____
_____
_____
_____
_____

Has your child ever been hospitalized? ____ Yes ____ No
If Yes, why and when? (Please list in chronological order) _____
_____
_____
_____
_____

Accidental trauma is the number one cause of injury to children in the United States each year. Please list any and all injuries experienced by your child, how they occurred and what action was taken to correct them.

_____
_____
_____
_____

Please check any of the following sports activities that your child is engaged in.

____Football	____Lacrosse	____Soccer	____Track/Field
____Bowling	____Tennis	____Hockey	____Volleyball
____Baseball/Softball	____Skateboarding	____Snowboarding	____Skiing
____Gymnastics/Trampoline	____BMX/Motorcross	____Swimming	____Golfing

Has your child ever been injured while playing sports? ____ Yes ____No
If yes, what type of injury(s) occurred? _____
_____
_____
_____
_____
_____

Recent research reveals that 30% of American children are obese with more than 50%of all US children overweight. On a scale from 1-5, please rate the food groups that are most eaten by your child on a daily basis. Use the higher number for the most common foods eaten.

__1 __2 __3 __4 __5	__1 __2 __3 __4 __5	__1 __2 __3 __4 __5	__1 __2 __3 __4 __5
Non-Complex Carbohydrates Bread Products, Cereals, Pizza, Cakes, Cookies, Chocolate, Candy	**Complex Carbohydrates** Fruits and Vegetables	**Protein** Nuts , Seeds, Meats, Eggs	**Fats** Dairy Products

Please list the (3) most common foods eaten by your child each day _____
_____

How many times per month does your child eat fast food? _____
What type? _____

What is the primary beverage consumed by your child? _____

How much water does your child drink each day? _____

Does your child drink soda? ___Yes ___No If yes, how much on a daily basis? _____

Does your child consume artificial sweeteners such as those found in sugarless, fat free products? ____Yes ____No
If yes, What type of artificial sweeteners does your child use? _____

Was your child breast fed? ____ Yes ____ No If Yes, for how long? _____
Was your child formula fed? ____ Yes ____ No If Yes, for how long? _____
At what age did you introduce solid foods into your child's diet? _____ What type(s)? _____
_____

Has your child exhibited any tolerance and/or allergy to any specific food? ____Yes ____No
If yes, please list all foods. _____
_____

Has your child been tested for allergies? ____Yes ____No
If yes, how were the tests performed? _____
What were the results? _____
_____

If your child does have an allergy, how does it present itself? (skin rash, hives, ENT/respiratory, digestive symptoms) _____
_____
_____
Has your child received treatment for any type of allergy? ____Yes ____No
If yes, what type of treatment? _____
_____
_____
_____