Name: _____ Date: _____
Address: _____ City_____ State____ Zip_____
Birthday:_____ Phone Number:_____
Parent Name(s)/Birthday(s)_____
# of Siblings: _____ Names:_____

What is the chief complaint?
_____
_____
How do you believe the problem began?
_____
_____
Have they ever had this condition or something similar before? When?
_____
_____
What makes it better? _____
What makes it worse? _____

Have they been under the care of another health care provider for this condition? When?
_____
Do they have any other health concerns?
_____
_____
Have they ever been in any accidents (ie. Auto, falls from stairs or bed?)
_____
_____
What surgeries has the child had? _____ Year _____
_____ Year _____
_____ Year _____
What medication is the child taking? (including aspirin, etc)
_____
_____
What vitamins and supplements do they take?
_____
_____

**Birth Information**
Birth Weight: _____ Birth Length _____
Current Weight:_____ Current Length/Ht:_____
Third Trimester Presentation: Vertex_____ Breech_____ Transverse_____ Face_____
Was the pregnancy full-term (38-42 wks)?_____ If not, how long:_____
Type of Birth: Normal Vaginal_____ Forceps_____ Cesarean_____ Vacuum_____
Location: Hospital_____ Home_____ Birthing Center_____
Problems during pregnancy? _____
_____
Problems during Labor/Delivery? _____
_____
APGAR Score: _____ Presence at birth of: Jaundice(yellow)/Cyanosis(Blue)?_____

Congenital Anomalies/Defects? _____

Infant Feeding: Breast_____ If so, How Long? _____
Bottle_____ If Bottle, Which Formula? _____
Number of Hours Sleeping Per Night: _____ Sleep Quality: Good___ Fair___ Poor__

Obstetrician/Midwife: _____
Pediatrician/Family MD: _____
Date of Last Visit: _____ Reason for Visit: _____
Immunization History: _____
Number of Doses of Antibiotics Taken in Last 6 Months: _____
Has your child been treated by a Chiropractor? _____ Purpose_____
Has your child ever been treated on an Emergency Basis? _____ Purpose_____
_____

**Case History**

At what age did the child:
Respond to Sound _____ Hold Head Up _____ Sit Alone _____
Crawl _____ Stand _____ Walk Alone _____
At what age, if ever, did the child suffer from the following childhood diseases?
Chicken Pox _____ Mumps _____ Measles _____ Rubella _____
Rubeola _____ Whooping Cough _____ Other _____

**Has this child ever suffered from:**

| | Now | Past | | Now | Past |
|---|---|---|---|---|---|
| Headaches | ____ | ____ | Loss of Balance | ____ | ____ |
| Neck Pain | ____ | ____ | Sleeping Problems | ____ | ____ |
| Allergies | ____ | ____ | Earaches | ____ | ____ |
| Fainting | ____ | ____ | Asthma | ____ | ____ |
| Back Pain | ____ | ____ | Diarrhea | ____ | ____ |
| Nervousness | ____ | ____ | Feet/Hands Cold | ____ | ____ |
| Seizure | ____ | ____ | Colic | ____ | ____ |
| Irritability | ____ | ____ | Ruptures/Hernia | ____ | ____ |
| Chest Pains | ____ | ____ | Muscle Spasms | ____ | ____ |
| Dizziness | ____ | ____ | Frequent Colds | ____ | ____ |
| Upset Stomach | ____ | ____ | Shoulder/Neck/Arm Pain | ____ | ____ |
| Constipation | ____ | ____ | Pins & Needles in Arm | ____ | ____ |
| Cold/Flu | ____ | ____ | Pins & Needles in Legs | ____ | ____ |
| Fever | ____ | ____ | Numbness in Fingers | ____ | ____ |
| Sinus Problems | ____ | ____ | Numbness in Toes | ____ | ____ |
| Diabetes | ____ | ____ | High Blood Pressure | ____ | ____ |
| Reflux | ____ | ____ | Behavioral Problems | ____ | ____ |
| Allergies | ____ | ____ | Leg Cramps | ____ | ____ |
| Colitis | ____ | ____ | Weakness in Arms | ____ | ____ |
| Gall Bladder | ____ | ____ | Weakness in legs | ____ | ____ |
| Indigestion | ____ | ____ | Shortness of Breath | ____ | ____ |
| Fatigue | ____ | ____ | Scoliosis | ____ | ____ |
| Depression | ____ | ____ | Vomiting | ____ | ____ |
| Shoulder Pain | ____ | ____ | Lights Bother Eyes | ____ | ____ |
| Swelling Joints | ____ | ____ | ADD/ADHD | ____ | ____ |
| Ears Ring | ____ | ____ | Knee Pain | ____ | ____ |
| Face Flushed | ____ | ____ | Bed Wetting | ____ | ____ |

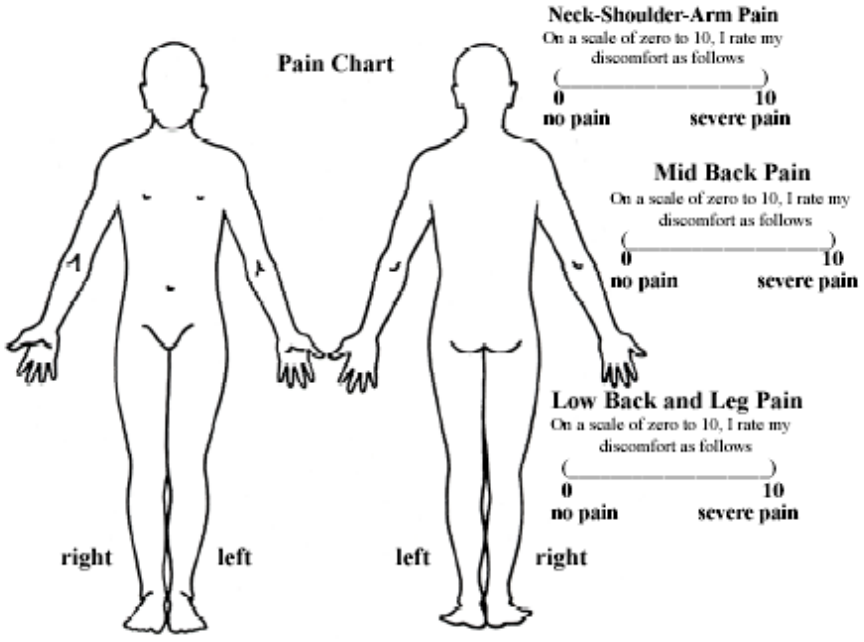
Has the child ever sustained any injuries playing sports?____ If yes, please explain:_____
_____
_____
Present History: _____
_____
_____
Family History: _____
_____
_____
Allergies:
_____
_____

**SHOW AREA(S) OF PAIN OR UNUSUAL FEELING**

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

| Numbness | Pins & Needles | Burning | Aching | Stabbing |
|---|---|---|---|---|
| - - - - - | OOOOO | xxxxx | ***** | / / / / / |
| - - - - - | OOOOO | xxxxx | ***** | / / / / / |

Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.



**DOLAN FAMILY CHIROPRACTIC LLC**
**PATIENT CONSENT**
**FOR USE AND/OR DISCLOSURE OF**
**PROTECTED HEALTH INFORMATION**
**TO CARRY OUT TREATMENT, PAYMENT**
**AND HEALTHCARE OPERATIONS**

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. Dolan Family Chiropractic Privacy notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for Dolan Family Chiropractic and to provide treatment to me, and also necessary for the Dolan Family Chiropractic to obtain payment for that treatment and to carry out it's health care operations. Dolan Family Chiropractic explained to me that the Privacy Notice will be available to me in the future at my request. The Dolan Family Chiropractic has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy notice carefully prior to my signing this Consent.
2. Dolan Family Chiropractic reserves the right to change it's privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by Dolan Family Chiropractic: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. Dolan Family Chiropractic may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for Dolan Family Chiropractic to treat me and obtain payment for that treatment, and as necessary for Dolan Family Chiropractic to conduct its specific health care operations.
5. I understand that I have a right to request that Dolan Family Chiropractic restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, Dolan Family Chiropractic is not required to agree to any restrictions that I have requested. If Dolan Family Chiropractic agrees to a requested restriction, then the restriction is binding on Dolan Family Chiropractic.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that Dolan Family Chiropractic has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, Dolan Family Chiropractic has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then Dolan Family Chiropractic will not treat me.

**I have read and understand that foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor): Relationship

Date Signed _____/____/____ Witness:_____