Cantalupo Chiropractic
516-334-3636
Date: ___/___/___

Note: Please answer all questions. If it does not apply, please write **n/a** (for not applicable).--Thank you!

Regarding Children: My responsibility as your Chiropractor is to examine and evaluate your child's spine for the presence of "vertebral subluxation". *(Vertebral subluxations are spinal mis-alignments that alter nervous system function & limit the full expression of health, growth and normal development).*

Child's name: _____ Age:____ DOB: ____/____/____

Parents/ guardian name(s):_____Relationship:_____

Address:_____ Town_____ Zip_____

Phone #'s : home: _____ Cell:_____ Work:_____

About the pregnancy:

Did you carry to full term? Y N explain: _____

Describe any pregnancy/delivery complications :_____

Did you use:☐ a midwife? ☐ Hospital? ☐ Obstetrician? ☐ Delivery by C section?
Did they use: ☐ forceps / ☐ vacuum extraction ☐ Epidural ☐ Induced labour
Was it a difficult birth? Y N. Explain: _____

What was the baby's **APGAR** Score at delivery? ____ and at 5 minutes? _____

During your pregnancy:
Did you breastfeed? Y N How long?_____ What formula after?_____
Did you drink alcohol? Y N Did you smoke? Y N
Did you use any medications (even over the counter) Y N
Which/for what? _____
Was your child exposed to ultrasounds? Y N How many times? _____

Is your child **vaccinated**? Y N . ☐ All required ☐ not-vaccinated by choice
Any **reactions** to any of the vaccinations noticed? Y N If yes, what reaction and to which vaccination? _____
Were you told that you had a **choice** in vaccinating your child? Y N
(If you would like more information about vaccinations, visit our web site and enter "vaccination" in our article search box.)

Has your child been **hospitalized** for any reason? Y N Explain:_____
_____.
Please note here if your child was **seen by any other healthcare providers** for this problem(s) & by whom? _____.

Has your child **fractured** any bones, had any major falls or been involved in a motor vehicle accidents? Y N Explain: _____

_____

Treated with **antibiotics** how many times? _____. For what? _____

_____.

Is your child currently taking <u>any</u> **medication** at all, including over the counter meds? Y N . If yes, explain: _____.

_____.

Injuries, trauma, health issues: please note major or recurring issues.

From <u>birth to 3</u> years of age, did any of the following occur? P=past C=currently

___ Fall from a change table
___ Tumble down stairs
___ Fall out of crib
___ Fall off playground equip.
___ Played in Jolly Jumper
___ Sleeping problems
___ Did not gain weight
___ Reaction to vaccination
___ Depression/anxiety

___ Frequent crying spells/colic
___ Frequent fevers
___ Frequent diarrhea
___ Frequently constipation
___ Frequent ear infections
___ Frequent colds
___ Tonsillitis
___ Illness:_____
___ Other: _____

Please explain the above: _____

_____

From age <u>4-18 years</u> of age did any of the following occur? P=past C=currently

___ Fall from a tree
___ Fall off a bicycle
___ Fall off playground equipment
___ Sports injury
___ Hyperactivity/Autism
___ Learning difficulties
___ Constipation
___ Frequent colds

___ Bed wetting/bladder issues
___ Stomach/digestive issues
___ Upper resp. infections
___ Asthma
___ Allergies
___ Diarrhea
___ Ear infections
___ Tonsillitis

___ Headaches
___ Dizziness
___ Ringing in ears
___ Asthma
___ Hyperactivity
___ Weight gain/loss
___ Scoliosis

___ Numbness: arms/legs
___ Tingling in arms/legs
___ Sleeping problems
___ Allergies
___ Fatigue
___ Growing Pains: where_____
___ Chronic illness (diabetes,etc.): _____

___ Pain: arms/legs
___ Neck/back pains
___ Shoulder/hip pain
___ Stomach problems
___ Depression/anxiety

Please explain any of the above: _____

_____.

***<u>If your child was **adopted,** please include any relevant information here:</u>

_____ .

Please note below any current symptoms or conditions that are of primary concern:

1. **Problem**: _____ Started when?_____
   How often it occurs: ☐ Constant ☐ Occasional ☐ Cyclical
   What makes it worse:_____ Better?_____
   What have you tried up to now that hasn't worked:_____
   _____
   How does it affect his/her behavior/quality of life?_____
   _____
   How does it affect the family situation:_____
   _____.

2. **Problem**: _____ Started when?_____
   How often it occurs: ☐ Constant ☐ Occasional ☐ Cyclical
   What makes it worse:_____ Better?_____
   What have you tried up to now that hasn't worked:_____
   _____
   How does it affect his/her behavior/quality of life?_____
   _____
   How does it affect the family situation:_____
   _____

   Any other health concerns? _____
   _____.

AUTHORIZATIONS

I, the undersigned, authorize Dr. Patricia Cantalupo to provide Chiropractic care to my minor dependent(s). I, the undersigned, authorize release of any medical information or other information necessary to process insurance claims for my minor dependent(s). I also request that payment of authorized insurance benefits be made, for my child or on their behalf, to Cantalupo Chiropractic if they take assignment of benefits, for any services furnished by Dr. Patricia Cantalupo or staff.

I authorize any holder of medical information about my children to release to my insurance carrier and/or Medicare and its agents any information needed to determine these benefits payable for related services.

I also give Cantalupo Chiropractic permission to obtain my children's records from their insurance company, attorney(s), or any of their doctors or hospitals/clinics as needed.

I am giving written permission for Dr. Patricia Cantalupo to make healthcare decisions regarding the Chiropractic care my children will receive since I, the parent/legal guardian listed below may not be present at all of his/her scheduled visits. I understand that I or another parent/legal guardian will and must be present for my child's first appointment. I also understand this signed consent will be valid until the minor child is 18 years of age, or unless I withdraw this permission in writing. When the child is no longer a minor, this authorization will still be in place unless the child, now an adult, withdraws this permission in writing.

I also acknowledge that I have read and understand this office's HIPAA policy document & was offered a copy of it. I realize that I may elect <u>not</u> to keep a copy of it, knowing that it I can elect to download it from the office web site. I attest to the fact that all the information provided on this form is accurate & truthful and that I have read and understand all the stated policies noted in this document.

Printed name (of legal guardian): _____
Signature (of legal guardian):_____**Date:** ___/___/___
<u>Relationship to child</u>: ☐father ☐mother ☐guardian*_____.