LifeTree Chiropractic
& Wellness, LLC

CONFIDENTIAL PATIENT CASE HISTORY
NEWBORN (BIRTH – 4 YEARS OLD)

Dear Parent:
Please complete this questionnaire. Your answers will help us determine if chiropractic can help your child. If we do not sincerely believe your child's condition will respond satisfactorily, we will not accept your child's case. THANK YOU.

Child's Name _____ Age_____ DOB _____
Address _____ City _____ State_____ Zip Code _____
Parent's Information: Name_____ Home # _____
Work # _____ Cell # _____ Referred by _____
Nearest Relative and Telephone: _____

BIRTH HISTORY:

Delivery: Vaginal Forceps Vacuum Extraction C-Section
Infant Feeding: Breast Bottle Formula
APGAR score: _____ Was there presence at birth of: Jaundice Cyanosis
Congenital Anomalies / Defects: _____

HEALTH INFORMATION:

Is your child here for: Wellness Checkup Specific Complaint
Please explain: _____
How long has your child had this condition? _____ has your child had this condition in the past? Y N
Which activities aggravate your child's condition? _____
Is their condition getting progressively worse? YES NO
Is their condition interfering with their: SCHOOL SLEEP DAILY ROUTINE OTHER
Name of Pediatrician: _____
Other doctors who treated this condition: _____
List surgical operations and years: _____
Medications your child now takes: over the counter Pain/Fever Reducer Allergy Medicine
Vitamins Others _____
Has your child suffered from: Colic Ear Infection Recurrent Cold Chronic Cough Asthma
Do you feel your child is sick quite often? YES NO
Has your child been in an auto accident, even a minor "fender – bender"? YES NO
If yes, Describe: _____

INSURANCE INFORMATION:

Name of Insurance: _____

Insured's Name: _____ Insured DOB: _____ Insured SSN # _____

AUTHORIZATION OF CARE OF A MINOR:

I hereby authorize this office and its doctor to administer care as they deem necessary to my son / daughter / ward (upon approval of parent or guardian).
Signed: _____ Date: _____

Parent/Guardian Printed Name: _____ Home #:_____