KNIGHT FAMILY CHIROPRACTIC

☐ DURANT, OK	☐ DENISON, TX	☐ SHERMAN, TX	☐ ANNA, TX
1004 N. 19th Ave., Bldg. 2	3230 S. Eisenhower Pkwy.	2021 N. Heritage Pkwy.	1108 W. White St., Ste 100
Durant, OK 74701	Denison, TX 75020	Sherman, TX 75092	Anna, TX 75409
P: 580.448.4412	P: 903.465.1881	P: 903.892.3471	P: 469.840.4111

PATIENT INFORMATION:

DATE: _____

CHILD'S NAME: _____ DOB: _____

PARENT/GUARDIAN'S NAME: _____

CELL #: _____ CELL CARRIER: _____

ADDRESS: _____

EMAIL ADDRESS: _____

HAS YOUR CHILD HAD PREVIOUS CHIROPRACTIC CARE? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DR'S NAME: _____ LAST DATE SEEN: _____

WERE X-RAYS TAKEN? ☐ YES ☐ NO

WHO IS YOUR MEDICAL PEDIATRICIAN? _____

PRENATAL HISTORY:

IS YOUR CHILD ADOPTED? ☐ YES ☐ NO

DID YOU HAVE ANY COMPLICATIONS? ☐ YES ☐ NO IF YES, PLEASE ELABORATE: _____

_____

DID YOU SMOKE? ☐ YES ☐ NO DID YOU CONSUME ALCOHOL? ☐ YES ☐ NO

DID YOU TAKE MEDICATION? ☐ YES ☐ NO REASON FOR MEDICATIONS: _____

_____

BIRTH HISTORY:

DID YOU HAVE AN ULTRASOUND DURING PREGNANCY? ☐ YES ☐ NO

WHAT WAS THE FREQUENCY: _____

PLACE OF BIRTH: ☐ HOME ☐ BIRTHING CENTER ☐ HOSPITAL

PROVIDER: ☐MIDWIFE ☐OB/GYN ☐ OTHER _____

TYPE OF BIRTH: ☐VAGINAL ☐ C-SECTION

WERE PAIN MEDICATIONS USED? ☐ YES ☐ NO EPIDURAL? ☐ YES ☐ NO

WAS LABOR INDUCED? ☐ YES ☐ NO IF YES, WHY: _____

WHAT POSITION DID YOU DELIVER IN? ☐SQUATTING ☐ ON BACK ☐ OTHER _____

BIRTH TRAUMA? ☐ DOCTOR ASSISTED ☐ TWISTING &/OR PULLING ☐VACUUM EXTRACTION
☐ FORCEPS ☐ CORD AROUND NECK

NEWBORN TRAUMA (MEDICAL PROCEDURES & TESTS):

APGAR SCORE: BIRTH ____/10 5-MINS ____/10 ☐ UNSURE

DID YOUR CHILD HAVE A MISSHAPEN SKULL/HEAD? ☐ YES ☐ NO

WERE THERE PURPLE MARKINGS ON THEIR FACE? ☐ YES ☐ NO

DID YOU BREAST FEED YOUR CHILD? ☐ YES ☐ NO

DOES YOUR CHILD PREFER ONE BREAST OVER THE OTHER? ☐ YES ☐ NO

IF YES, WHICH SIDE: ☐ RIGHT ☐ LEFT

DOES YOUR CHILD HAVE FOOD ALLERGIES? ☐ YES ☐ NO

IF YES, PLEASE LIST: _____

HAS YOUR CHILD BEEN IMMUNIZED? ☐ YES ☐ NO

REASON FOR VACCINATION? ☐ INFORMED CONSENT ☐ RECOMMENDED ☐ DIDN'T KNOW I HAD A CHOICE

DID YOUR CHILD HAVE ANY ADVERSE REACTIONS TO THE VACCINATIONS? ☐ YES ☐ NO

WERE THEY REPORTED? ☐ YES ☐ NO

HAS YOUR CHILD EVER HAD ANY SURGERIES? ☐ YES ☐ NO

IF YES, PLEASE ELABORATE: _____

HAS YOUR CHILD BEEN ON ANTIBIOTICS? ☐ YES ☐ NO

IF YES, HOW OFTEN & FOR WHAT? _____

IS YOUR CHILD CURRENTLY TAKING ANY MEDICATION? ☐ YES ☐ NO IF YES, WHAT: _____

IS YOUR CHILD CURRENTLY TAKING ANY VITAMINS? ☐ YES ☐ NO IF YES, WHAT: _____

BABY/TODDLER (0-4):

HAVE ANY OF THE FOLLOWING OCCURRED?

☐ FALL FROM A CHANGING TABLE	☐ FREQUENT CRYING SPELLS	☐ TUMBLE DOWNSTAIRS
☐ CAR ACCIDENT	☐ FALL OUT OF A CRIB	☐ FALL OFF PLAYGROUND EQUIPMENT
☐ PLAY IN A JOHNY JUMPER	☐ FREQUENT EAR INFECTIONS	☐ TONSILLITIS
☐ REACTION TO VACCINES	☐ FREQUENT FEVERS	☐ FREQUENT DIARRHEA
☐ CONSTIPATION	☐ SLEEPING PROBLEMS	☐ REPEATED INFECTIONS (IE: STREP)
☐ COLIC	☐ (+ OR -) WEIGHT GAIN	☐ LATCHING/BREAST FEEDING DIFFICULTY

☐ OTHER (PLEASE EXPLAIN)_____

CHILD (5-12):

HAVE ANY OF THE FOLLOWING OCCURRED?

☐ FALL FROM A TREE	☐ FALL OFF A BICYCLE	☐ SPORTS ACCIDENT/INJURY
☐ CAR ACCIDENT	☐ STOMACH PAINS	☐ FALL OFF PLAYGROUND EQUIPMENT
☐ BED WETTING	☐ HYPERACTIVITY/AUTISM	☐ SCOLIOSIS
☐ LEARNING DIFFICULTIES	☐ ASTHMA	☐ ALLERGIES
☐ LEG/KNEE PAINS	☐ OTHER (PLEASE EXPLAIN) _____	

_____

ALL AGES:

WHICH OF THE ABOVE BOTHERS YOUR CHILD THE MOST? _____

WHEN DID IT BEGIN? _____

IS IT GETTING WORSE? ☐ YES ☐ NO

IS THE PAIN: ☐ CONSTANT ☐ INTERMITTENT ☐CYCLIC

AFFECT ON ACTIVITY: ☐ NOT AT ALL ☐ SOMEWHAT ☐ ALWAYS

DOES YOUR CHILD PARTICIPATE IN ANY OF THE FOLLOWING?

☐ SOCCER	☐ FOOTBALL	☐ GYMNASTICS	☐KARATE
☐ HOCKEY	☐ LACROSSE	☐ BASKETBALL	☐ DANCE
☐ WRESTLING	☐ BASEBALL/SOFTBALL	☐ VOLLEYBALL	☐ TENNIS
☐ SWIMMING	☐ RUGBY	☐ OTHER: _____	

HOW WOULD YOU RATE YOUR CHILD'S DIET? ☐ WELL BALANCED ☐ AVERAGE ☐ HIGH SUGAR/PROCESSED FOODS

DOES YOUR CHILD COMSUME ARTIFICIAL SWEETNERS? ☐ YES ☐ NO

FLOURIDATED WATER? ☐ YES ☐ NO

NUMBER OF HOURS YOUR CHILD SLEEPS? _____ PER DAY

SLEEP QUALITY? ☐ GOOD ☐ FAIR ☐ POOR

AUTHORIZATION TO TREAT A MINOR

I, _____, THE UNDERSIGNING PARENT/GUARDIAN HAVING LEGAL CUSTODY/GUARDIANSHIP OF _____, A MINOR, DO HEREBY AUTHORIZE, REQUEST AND DIRECT KNIGHT FAMILY CHIROPRACTIC AND WHOMEVER THEY MAY DESIGNATE AS AN ASSISTANT TO PERFORM IN JUDGEMENT ANY EXAMINATION AND CHIROPRACTIC DIAGNOSIS OR TREATMENT WHICH IS DEEMED NECESSARY.

ANY SPECIFIC WRITTEN AUTHORIZATION YOU PROVIDE MAY BE REVOKED AT ANY TIME BY WRITING TO OUR OFFICE.

PATIENT: _____ SIGNATURE: _____

PRINT NAME PARENT/LEGAL GUARDIAN

DATE: _____