

CHILD PATIENT INFORMATION CARD

Date _____ Social Security # _____
Name _____ Parent/Guardian _____
Last First Middle Initial
Address _____ City _____ St _____ Zip _____
Phone _____ Cell _____ E-mail _____
Date of Birth _____ Age _____ ☐ M ☐ F Ht: ____ ft. ____ in. Wt. _____ Referred By _____

DOES YOUR CHILD HAVE ANY DIFFICULTY WITH ANY OF THE FOLLOWING? CHECK ALL THAT APPLY:

- | | | | |
|-----------------------------------------------|---------------------------------------------------------|-------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Fainting or Seizures | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Irritability / Moodiness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sleeping Trouble | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diarrhea / Constipation |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Groin Pain |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Eye / Vision Trouble | <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Pain in Shoulder / Arm | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Leg / Foot Pain |
| <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Chest or Rib Pain | <input type="checkbox"/> Liver Trouble | <input type="checkbox"/> Buttocks Pain |
| <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Hearing Difficulties | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Hip Pain |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Nerves, Nervousness | <input type="checkbox"/> Painful Menstruation | <input type="checkbox"/> Tailbone / Sacrum Pain |
| <input type="checkbox"/> Growing / Back Pains | <input type="checkbox"/> Stress / Anxiety | <input type="checkbox"/> Irregular Menstruation | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Mid Back / Shoulder Blade Pain | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Other _____ |

Other **doctors seen** for this condition _____

List all **surgeries** and when _____

List all **medications / antibiotics** and what they're for _____

Previous chiropractic care? ☐ Yes ☐ No When? _____ Where? _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (i.e.: a bed, changing table, down the stairs, etc). **Was this the case with your child?** ☐ Yes ☐ No

Is / has your child been involved in any **high impact or contact type sports**? (soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.) ☐ Yes ☐ No List any and all accidents, traumas or injuries and dates: _____

Has your child ever been involved in a **car accident**? ☐ Yes ☐ No _____

Has your child ever been seen on an **emergency basis**? ☐ Yes ☐ No _____

Has your child had **any of the following**:

Chicken Pox ☐ Yes ☐ No Age _____ Mumps ☐ Yes ☐ No Age _____ Whooping Cough ☐ Yes ☐ No Age _____
Rubella ☐ Yes ☐ No Age _____ Rubeola ☐ Yes ☐ No Age _____ Other _____ Age _____

Primary / Family Doctor: Name, address, phone _____

Primary Insurance _____ Subscriber's Date of Birth _____

Subscriber's Employer _____ Subscriber's SS# _____

Secondary Insurance _____ Subscriber's Date of Birth _____

Subscriber's Employer _____ Subscriber's SS# _____

Authorization for Care of Minor: I hereby authorize this office and its Doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payments of all fees charged by this office.

Parent/Guardian Signature _____ Date _____

PRE-SCHOOL to SCHOOL AGE CHILD HISTORY (2-18 years)

Child's Name _____ Parent/Guardian _____ Date _____

The following questions are designed to help the doctor provide the best possible spinal care for your child.

Main reason for coming to the office today: _____

☐ Yes ☐ No Any complaints of pain or discomfort? If yes, when did this begin? _____
Was the onset: ☐ sudden ☐ gradual Is the problem: ☐ constant ☐ intermittent

☐ Yes ☐ No Has this been a problem before _____

☐ Yes ☐ No Has there been previous treatment for this problem? By whom? _____

☐ Yes ☐ No Previous chiropractic care? Previous chiropractor _____

Health History

☐ Yes ☐ No Any complaints of ☐ back pain ☐ neck pain ☐ leg pain ☐ arm pain _____

☐ Yes ☐ No Any complaints of headaches _____

☐ Yes ☐ No Have/had asthma _____

☐ Yes ☐ No Allergic to anything _____

☐ Yes ☐ No History of ear aches? What age was the first occurrence? _____ How frequently are they? _____
Which ear do they usually occur? ☐ Left ☐ Right ☐ Both _____

☐ Yes ☐ No Issues with bed wetting _____

☐ Yes ☐ No Presently taking prescribed medications _____

List any other illnesses which have been a concern for the child _____

Trauma

List any falls (bicycle, skateboard, scooter, rollerblades, etc) _____

List any sports/hobby related injuries _____

Lifestyle

What grade in at school _____

How are school books carried _____

How heavy is school book bag _____

What sports are played _____

What hobbies does child have _____

How many hours are spent each day:

Watching TV _____

Playing video games _____

Using a computer _____

How many hours of sleep per night _____

Any smokers in the family ☐ Yes ☐ No _____

Feel stressed out ☐ Yes ☐ No _____

Trouble reading the board in class ☐ Yes ☐ No _____

Ever have blurred vision ☐ Yes ☐ No _____

Wear contact lenses ☐ Yes ☐ No _____

Headaches when reading ☐ Yes ☐ No _____

Nutrition

How much of the following does child consume each day?

Cow's milk _____

Water _____

Fast food _____

Sodas or colas _____

☐ Yes ☐ No Any food allergies _____

☐ Yes ☐ No Any persistent or intermittent skin rashes _____

☐ Yes ☐ No Any vitamin supplements _____

☐ Yes ☐ No Eliminate stools each day _____

Do you have any concerns about your child's diet _____

Do you have any other concerns you wish to discuss: _____



PREGNANCY / BIRTH HISTORY, DEVELOPMENTAL MILESTONES

Child's Name _____ Parent/Guardian _____ Date _____
How many children do you have? _____ What was the term of your pregnancy? _____ weeks

Pregnancy History

During your pregnancy, did you have any of the following?

- ☐ Falls _____
- ☐ Motor Vehicle Accidents _____
- ☐ Near-miss Accidents _____
- ☐ High blood pressure _____
- ☐ Diabetes _____
- ☐ Anemia _____
- ☐ Morning Sickness _____
- ☐ Indigestion _____
- ☐ Seizures _____
- ☐ Swollen ankles _____
- ☐ Thyroid problems _____
- ☐ Heart problems _____
- ☐ Back pain _____
- ☐ Abnormal bleeding _____

- ☐ Were you hospitalized _____
- ☐ Any other illnesses _____

During your pregnancy, did you use any of the following?

- ☐ Tobacco _____
- ☐ Alcohol _____
- ☐ Non-prescribed drugs _____
- ☐ Prescription drugs:
 - Medication _____
 - Reason _____
- ☐ Over-the-counter medications
 - Medication _____
 - Reason _____

Birth History

Labor and Delivery

How long was the labor from the **first regular contractions** to the birth? _____ hours

How long was the **2nd stage** (the pushing phase) of the labor? _____ hours

- ☐ Hospital birth _____
- ☐ Home birth _____
- ☐ Midwife assisted _____

- ☐ Vaginal delivery _____
- ☐ Planned C-section _____
- ☐ Emergency C-section _____

- ☐ Was birth induced (Pitocin) _____
- ☐ Forceps delivery _____
- ☐ Vacuum extraction _____

- ☐ Anesthesia administered _____
- ☐ Fetal distress _____
- ☐ Meconium staining _____

- ☐ Head presentation _____
- ☐ Face presentation _____
- ☐ Breech presentation _____

Apgar scores

At 1 minute ____ / 10
At 5 minutes ____ / 10

Baby's Crying

- ☐ Baby cried immediately after birth
- ☐ Cried strongly
- ☐ Weak cry
- ☐ Did not cry for ____ minutes

Baby's color

- ☐ Pink all over
- ☐ Blue face
- ☐ Blue hands/feet

Baby's activity

- ☐ Arms and legs actively moving
- ☐ Floppy baby

Intensive care

- ☐ Was required
- ☐ Days in neonatal intensive care unit

Medication given at birth? _____

Vaccines administered _____

Birth **weight** _____ lbs/kgs

Birth **length** _____ ins/cms

Baby **home on day** _____

Baby's Condition Immediately After Birth

Child's Name _____ Parent/Guardian _____ Date _____

Developmental Milestones

Please indicate the most complex skill that your child can perform in each section.

In each section, the tasks are arranged in order of increasing developmental age.

Gross Motor Skills

- ☐ Able to hold head up from the table momentarily
- ☐ Head and shoulder can be supported by the forearms
- ☐ Infant can be pulled up into a sitting position by the hands
- ☐ Sits unsupported in upright position
- ☐ Head and shoulders can be supported by the arms
- ☐ Rolls from prone to supine by the arms
- ☐ Crawls
- ☐ Stands holding onto furniture
- ☐ Walks with someone holding onto one hand
- ☐ Walks unassisted
- ☐ Runs
- ☐ Negotiates stairs placing 2 feet on each step
- ☐ Climbs stairs with one foot on each step
- ☐ Hops on one foot

Social Skills

- ☐ Smiles
- ☐ Reaches for familiar objects
- ☐ Plays with hands
- ☐ Plays with feet
- ☐ Clearly shows joy and pleasure
- ☐ Feeds self with fingers
- ☐ Plays peek-a-boo
- ☐ Understands yes and no

Fine Motor Skills

- ☐ Primitive grasp reflex present
- ☐ Holds and shakes a rattle placed in hand
- ☐ Grasps objects independently
- ☐ Moves an object from one hand to the other
- ☐ Self-feeding, can hold and eat a cookie
- ☐ Checks objects by placing them in the mouth
- ☐ Picks up object with thumb and index finger
- ☐ Turns 2 to 3 pages of a book at a time
- ☐ Turns pages of book one at a time
- ☐ Builds a tower containing at least 5 blocks
- ☐ Builds a tower containing at least 10 blocks

Communication Skills

- ☐ Makes cooing sounds
- ☐ Laughs
- ☐ Uses one syllable words such as 'da'
- ☐ Uses two syllable words such as 'dada'
- ☐ Uses 2 to 3 word vocabulary
- ☐ Uses 2 to 3 word phrases

Adaptive Skills

- ☐ Feeds from a cup unassisted
- ☐ Holds own bottle
- ☐ Feeds self with utensils
- ☐ Able to identify and match some colors
- ☐ Copies a circle
- ☐ Copies a cross

Trauma

Has your child:

- ☐ Yes ☐ No Had any recent falls or trauma? Please describe the trauma and date it occurred: _____
- ☐ Yes ☐ No Ever fallen down stairs or fallen from any height _____
- ☐ Yes ☐ No Ever been in a motor vehicle collision or near miss _____
- ☐ Yes ☐ No Ever had a bone fracture or joint dislocation _____
- ☐ Yes ☐ No Had any other trauma or injuries _____
- ☐ Yes ☐ No Ever bang his/her head repeatedly against a wall, bed or other object? _____

List any **surgeries** your child has had _____

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CONSENT FOR CARE OF MINOR CHILD

I, _____, request and consent to the release of information for the purpose of treatment at Dr. Joseph Lupo's office **and to administer chiropractic care as deemed necessary to my child,** _____.

Parent/Guardian Signature _____ Date _____