27850 Gratiot Avenue
Roseville, MI 48066
Phone (586) 772-5876
Fax (586) 772-1122

LUPO chiropractic center

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:**

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

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NEWBORN to INFANT HISTORY (Birth - 2 years)

Child's Name _____ Parent/Guardian _____ Date _____

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

Nutrition

❑ Yes ❑ No Being breast fed? If no, for how long was baby breast fed _____ weeks/months

If still breast feeding, how much cow's milk does the mother consume each day? _____

❑ Yes ❑ No Formula fed? Which formula or other milk source _____

❑ Yes ❑ No Have any feeding difficulties _____

How many hours does your baby sleep between feeds? During the day _____ At night _____

❑ Yes ❑ No Is child eating solid food? What does his/her diet contain? _____

❑ Yes ❑ No Any digestive disturbances _____

❑ Yes ❑ No Any food allergies _____

❑ Yes ❑ No Any persistent or intermittent skin rashes _____

❑ Yes ❑ No Receiving any vitamin supplements _____

Does the child:

❑ Yes ❑ No Go to sleep easily _____

❑ Yes ❑ No Have a preferred sleeping position _____

❑ Yes ❑ No Cry if you change this sleeping position _____

❑ Yes ❑ No Have a one-sided breast feeding preference? ❑ left ❑ right

❑ Yes ❑ No Frequently spit-up after feeding _____

❑ Yes ❑ No Cry a lot? For how many hours each day? _____

❑ Yes ❑ No Pass a lot of intestinal gas? _____

❑ Yes ❑ No Have a preferred head position _____

❑ Yes ❑ No Frequently arch his/her neck and neck backwards? _____

❑ Yes ❑ No Cry or become irritable during a diaper change _____

Has the child:

❑ Yes ❑ No Been vaccinated _____

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

_____

_____

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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 _____

Baby's Condition Immediately After Birth

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** _____

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 _____