Van Dam Chiropractic

Account Number:_________

BIOGRAPHICAL DATA Date____________________

A. Patient Name____
B. Sex______________________________________
C. Date of Birth_______________________________ Age____________________
D. Mailing Address____
____
E. Street Address if different than mailing address________________________________
____
F. Mother__________________________________ Email ___________________
Address_________________________________
____
Phone__________________________________
Occupation______________________________
G. Father_________________________________
Address_________________________________
____
Phone__________________________________
Occupation______________________________
H. Siblings
Name__________________________________Age_____________Sex__________
Name__________________________________Age_____________Sex__________
Name__________________________________Age_____________Sex__________
Name__________________________________Age_____________Sex__________
I. Native Language__________________________

FAMILY MEDICAL HISTORY

Please check if any blood relatives to the patient had any of the following illnesses and mark accordingly by noting M(mother); F)Father); PGM(paternal grandmother); MGM(maternal grandmother); PGF(paternal grandfather); or MGF(maternal grandfather).

_______________Allergy, Asthma or Eczema
_______________Cancer
_______________Diabetes or Low Blood Sugar
_______________Heart Trouble
_______________High Blood Pressure
_______________Kidney Disease
______________Liver Disease
______________Mental Retardation
______________Mental Illness
______________Scoliosis
______________Ulcer
______________Other_____________

PREGNANCY

Please check any areas that applied to the patient's mother during the pregnancy.

_____Complications
_____Medications
_____Recreational Drugs
_____Smoking
_____Alcohol
_____Caffeine: Cola
_____Caffeine: Coffee
_____Caffeine: Chocolate
_____Caffeine: Other
_____Vitamins/Minerals
_____Any Diagnosed Illnesses
_____Hospitalization
_____Bleeding
_____Premature Contractions
_____Back Pain
_____Other Pain
_____Excessive weight loss
_____Excessive weight gain
_____Toxic Exposures
_____Allergic Reactions
_____Mental Trauma
_____Physical Injury
_____Prenatal Classes
_____Carried to full term
_____Attitude-mostly happy
_____Attitude-mostly depressed

LABOR & DELIVERY
_____Greater than 12 hours
_____Complications
_____Fetal monitor used
_____Medications
_____Forceps
_____Caesarean
_____Hospital
_____Home birth
_____Premature Delivery
_____Vacuum Extraction
_____Other____

PRENATAL HISTORY-If known please indicate
The duration of the pregnancy was ___________weeks.
The apgar score at birth was ______________________.
The apgar score at five minutes was ________________.
The length at birth was __________________________.
The weight at birth was __________________________.

Please check any problems the patient had at birth.
_____Breathing
_____Coloring
_____Choking
_____Crying
_____Nursing
_____Sleeping
_____Jaundice
_____Other____________________________________

Please check if any item(s) applied to the patient at birth.
_____Medication
_____Artificial feeding
_____Vitamin K
_____Surgery
_____Erythromycin
_____Circumcision
_____Other____

NUTRITION
Please check if the patient has received any of the following items.

_____Breast milk	_____Sweets
_____Commercial formula	_____Fruit juice
_____Cow's milk	_____Vegetable juice
_____Goat's milk	_____Vitamins
_____Solid foods	_____Medications

_____Other____

IMMUNIZATION
Please list any immunizations the patient has received along with the date it was received and any reactions observed.

____
____
____
____

Note foreign travel.

____
____

ILLNESSES
Please list any illnesses and/or medications the patient has received along with the date it was received and any reactions observed.

____
____
____
____

FAMILY PHYSICIAN
Name of pediatrician and date of last visit.

____

GENERAL SYSTEM REVIEW

1. Has your child ever been unconscious or had a convulsion? Yes No
   If yes, please explain.____

____
____

2. Any problems with the eyes, including vision? Yes No
   If yes, please explain. ____

____
____

3. Has your child ever been cyanotic? (Turned blue) Yes No

If yes, please explain.____

4. Does your child tolerate exercise? Yes No
If yes, please explain.____

5. Any recurring problem with vomiting, diarrhea, constipation or stomach pain? Yes No
If yes, please explain.

6. Do the stools look or smell abnormal? Yes No
If yes, please explain.

7. Any unusual problem on passing urine or any unusual frequency? Any unusual smell or appearance of urine? Yes No
If yes, please explain.

8. Does your child complain of any extremity or back pain? Do you notice a limp or unusual gait pattern? Yes No
If yes, please explain.

9. Any allergies, eczema, hay fever, hives, asthma or reactions? Yes No
If yes, please explain.

10. Other problems?

ADDITIONAL INFORMATION
Use this space for further information concerning specific items previously checked.

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