Dr. Cree Guardino, BS, BA, DC, DICCP

Child's Full Name: Date:

Child's Social Security Number:

Parent #1 Name: Parent #2 Name:

Insured Parent's Social Security Number:

Child's Home Address:

City: State: Zip:

Home Phone:

Parent #1 Work Phone: Parent #1 Cell Phone:

Parent #2 Work Phone: Parent #2 Cell Phone:

Parent #1 Email Address: Parent #2 Email Address:

Birth Information

Birth Date: Sex: Birth Weight: Birth Length: Current Age of Child:

Type of Birth *(please circle)*: Vaginal Forceps Breech Cesarean Home Birthing Center Hospital

Medication taken during pregnancy? Epidural: Yes / No *(please circle)*

Any problems during pregnancy and/or labor?

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Apgar Scores: Jaundice (yellow) at Birth? Cyanosis (blue)?

Congenital Anomalies/Defects:

Infant Feeding *(please circle)*: Breast Bottle Formula Other Food or Drink Information:

Number of Hours Child Sleeps Daily: Quality of Sleep *(please circle)*: Good Fair Poor

Explain:

Number of Siblings: Siblings Name *(include Age/Sex)*:

Health and Medical Information

Obstetrician and/or Midwife Name: Location:

Pediatrician and/or Family MD Name: Location:

Date of Last Visit to Doctor: Purpose of that Visit:
Immunization History:

Has your child ever been treated on an emergency basis *(if Yes, please describe)*?

Purpose of the appointment today with the Chiropractor:

Pregnancy History:

Delivery/Birth History:

Development History *(indicate age when occurred)*

Respond to sound:

Crawl:

Follow an object with their eyes:

Hold head up:

Stand:

Sit alone:

Walk alone:

Childhood Diseases *(indicate age when occurred)*

Chicken Pox:

Rubella:

Rubeola:

Whooping cough:

Mumps:

Measles:

Other:

Has this child ever suffered from *(please check any that apply)*:

☐ Diabetes	☐ Bed Wetting	☐ Convulsions	☐ Neck Problems
☐ Fainting	☐ Tuberculosis	☐ Backaches	☐ Heart Trouble
☐ Dizziness	☐ Stomach Aches	☐ Allergies	☐ Orthopedic Problems
☐ Asthma	☐ Walking Problems	☐ Rheumatic Fever	☐ Hypertension
☐ Sugar Concentration	☐ Digestive Disorders	☐ Blood Disorders	☐ Broken Bones
☐ Sleeping Problems	☐ Constipation	☐ Sinus Trouble	☐ Leg Problems
☐ Diarrhea	☐ Hyperactivity	☐ Paralysis	☐ Joint Problems
☐ Arm Problems	☐ Neuritis	☐ Chronic Earaches	☐ Colds/Flu
☐ Arthritis	☐ Muscle Jerking	☐ Anemia	☐ Poor Appetite
☐ Behavioral Problems	☐ Headaches	☐ Ruptures/Hernias	☐ "Growing Pains"
☐ Any other problem(s)			

Present Health History or Additional Information:

Surgery Information:

Medications:

Accidents:

Family Health History:

Once again, we would like to welcome you to our office.

If you have any questions regarding your health and wellness care please don't hesitate to ask.