Quintessential CHIROPRACTIC
The Ultimate in Gentle, Effective Care

Child's Name: _____ Date of Birth: _____

Age: _____ Parent/Guardian Name:_____

Address: _____
Street

_____
City State Zip

Home #: _____ Work #: _____ Cell #: _____

Email address: _____

Emergency Contact: _____
Name Relationship Phone #

Appointment Reminder: Email ☐ Text ☐ Appointment Card ☐

Has your child been adjusted by a Chiropractor before? Yes ☐ No ☐

What was the reason for the visit? _____

Doctor's Name/Location: _____ Date of last visit: _____

Who can we thank for sending you to us? _____

CHILD'S COMPLAINT

Describe Reason for Today's Visit: _____

_____

When did you first notice it? _____ What caused it? _____

How is the condition now? ☐Better ☐Worse ☐Same ☐Comes and goes

When does it occur? _____ How often? _____

How long does it last? _____ Does it travel? _____

What makes it worse? _____

What makes it better? _____

16021 Kairos Rd, Suite C
South Chesterfield, VA 23834
www.quintchiro.com 804-536-6262 www.facebook.com/QuintChiro

CHILD'S COMPLAINT (cont'd)

The condition interferes with: School ☐ Sleep ☐ Daily Routine ☐ Other Activities ☐

Describe: _____

Have you had this condition before? Yes ☐ No ☐ When? _____

Have you seen another doctor for this? Yes ☐ No ☐ When? _____

Doctor's Name: _____ Phone #: _____

Type of Treatment/ Results: _____

_____

GENERAL HISTORY

Were there any complications during pregnancy or delivery? Yes ☐ No ☐

Describe: _____

_____

What position was your baby in during third trimester? _____

How was the child delivered? Home Birth ☐ Hospital ☐ Midwife ☐

Induced ☐ Forceps ☐ Vacuum ☐ C-Section ☐ Doctor twisted/pulled ☐

Are there any genetic diseases or birth defects? Yes ☐ No ☐

_____

What time is your child's bed time? _____

What time does your child wake up? _____

Please list your child's accidents, falls, injuries, and illnesses: (include dates) _____

_____

_____

Has your child had any surgeries or been hospitalized? Yes ☐ No ☐

When and for what? _____

_____

What activities/sports does your child participate in? _____

_____

_____

FEEDING HISTORY

Was your child breast fed? Yes ☐ No ☐ How long? _____

Did your child have a "preferred" side? Yes ☐ No ☐ Which? _____

Was your child formula fed? Yes ☐ No ☐ How long? _____

When did your child start eating solid foods? _____ Drinking milk? _____

Does your child have any food allergies/intolerances? Yes ☐ No ☐

Describe: _____

_____

Does your child have any digestive problems? Yes ☐ No ☐ Describe: _____

_____

VACCINE HISTORY

Has your child been vaccinated? Yes ☐ No ☐ Please list: (include dates) _____

_____

_____

Health is affected by your nervous system, but it is also affected by your environment, the foods you eat, and your lifestyle activities and habits. Chiropractic care is an important addition to a healthier lifestyle.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes in my child's medical status.

Parent/Guardian Name: _____ Relationship: _____

Guardian's Signature: _____ Date: _____

Please place a check mark beside any milestone that your child was delayed in achieving.

GROSS MOTOR SKILLS	
AGE	SKILL
4 wks	Able to hold head up from table momentarily
3 mths	Head & shoulder cab be supported by forearms
4 mths	Can be pulled into sitting position by hands
6 mths	Sits unsupported in upright position
6 mths	Head & shoulders can be supported by arms
6 mths	Rolls from face down to face up
9 mths	Crawls
9 mths	Stands holding on to furniture
11 mths	Walks with someone holding onto one hand
12 mths	Walks unassisted
2 yrs	Runs
2 yrs	Negotiates stairs – 2 feet on each step
3 yrs	Climbs stairs - one foot on each step
4 yrs	Walks down stairs – one foot on each step
4 yrs	Hops on one foot

FINE MOTOR SKILLS	
AGE	SKILL
Birth	Primitive grasp reflex
4 mths	Holds and shakes rattle placed in hand
5 mths	Grasps objects independently
6 mths	Moves an object from one hand to the other
6 mths	Self-feeding, can hold and eat a cookie
6 mths	Checks objects by placing in mouth
12 mths	Picks up object with thumb and index finger
15 mths	Turns 2-3 pages of a book at a time
18 mths	Turns pages of a book one at a time
24 mths	Builds a tower containing at least 5 blocks
4 years	Builds a tower containing at least 10 blocks

COMMUNICATION SKILLS	
AGE	**SKILL**
7 wks	Makes cooing sounds
3 mths	Laughs
5 mths	Uses one syllable words such as "da"
8 mths	Uses 2 syllable words such as "dada"
12 mths	Uses 2-3 word vocabulary

24 mths	Uses 2-3 word phrases

SOCIAL SKILLS	
AGE	SKILL
2 mths	Smiles
3 mths	Reaches for familiar objects
4 mths	Plays with hands
6 mths	Plays with feet
9 mths	Clearly shows joy and pleasure
12 mths	Feeds self with fingers
15 mths	Plays peek-a-boo
18 mths	Understands yes and no