Café of Life - Grant Park Life Story (Under 12)

Today's Date: _____

Minor's Name: _____ Date of Birth: _____

Age: _____ Sex: _____

Legal Guardian(s): _____/_____

Address: _____

Guardian's Phone #: _____ Guardian's Email: _____

Please list siblings' names and ages: _____

_____

What is the reason your child is seeking care here? _____

_____

Who can we thank for referring you today? _____

Please **circle** the following regarding your child's birth process:

Delivered where:	Hospital	home	birthing center	other_____
Instruments used:	None	forceps	vacuum	other_____
Complexity of birth:	easy	moderate	difficult	
Infant birth trauma:	bruising	odd shaped head	stuck in birth canal	
	Cord around neck	respiratory depression		other_____

What are your expectations and goals for chiropractic care? _____

(please complete back side of form)

Is your child currently seeking the services of another healthcare provider? N Y

Please provide the reason: _____

Is your child taking any prescription, over the counter or recreational drugs? N Y

Please list: _____

Has your child had any surgeries, hospitalizations or diagnoses we should know about?

_____

_____

Please list any other health concerns you may have for your child: _____

_____

Did/Does your child get breast fed? N Y If yes, for how long? _____

Does your child currently or in the past partake in any of the following:

Caffeine	N	Y	How often? _____
Artificial Sweeteners	N	Y	How often? _____
Sugar	N	Y	How often? _____
Fast Food	N	Y	How often? _____
Processed Food	N	Y	How often? _____
Dairy Products	N	Y	How often? _____
Organic Food	N	Y	How often? _____
Raw Foods	N	Y	How often? _____

Does your child have a normal sleeping pattern? N Y

Does your child participate in recreational sports? N Y What and how often? _____

_____

Has your child ever seen a chiropractor before? N Y Reason: _____
What was his/her experience? _____

Parent/Guardian Name: (print) _____ Date: _____

Parent/Guardian Signature: _____