Dr. Amanda Messer Messer Chiropractic and Nutrition Center (701) 255-6377

Child History

Patient Name: _____

Birth Date: _____ Age: _____ Gender: _____ Weight: _____ Height: _____

Names of Parents/Guardians: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Present Complaint

Purpose for Visit: _____

Have you seen other doctors for this condition? YES NO

Prior treatments and doctors' names: _____

Other Health Problems: _____

_____

Circle **any** of the following conditions your child has suffered from:

Ear Infections	Scoliosis	Seizures	Chronic Colds	Headaches
Asthma/Allergies	Digestive Problems	ADHD	Recurring Fevers	Growing/Back Pains
Colic	Bed Wetting	Motor Vehicle Accident	Temper Tantrums	Other: _____

Family History: _____

Name of Pediatrician: _____

Date of Last Visit: _____ Reason: _____

Number of doses of Antibiotics your child has taken in the past 6 months: _____ Lifetime: _____

Number of doses of Other Rx Medications your child has taken in the past 6 months: _____ Lifetime: _____

List: _____

Vaccination History: _____ Date of Last Vaccination: _____

Food allergies or intolerances? YES NO List: _____

_____

Developmental History

Childhood diseases:	Chicken pox	YES NO AGE: _____	Mumps	YES NO AGE: _____
	Rubella	YES NO AGE: _____	Whooping Cough	YES NO AGE: _____
	Measles	YES NO AGE: _____	Other	YES NO AGE: _____

Is/has your child been involved in any high impact or contact type sports (i.e., soccer football, gymnastics, baseball, cheerleading, martial arts, etc.) YES NO List: _____

_____

Has your child ever been involved in a car accident? YES NO List: _____

Has your child ever been seen on an emergency basis? YES NO List: _____

Other traumas not described above: _____

Prior surgery? YES NO List: _____

Menarche (females only)? YES NO Age: _____

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a chiropractor for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child first able to:

_____ Respond to sound
_____ Respond to visual stimuli
_____ Hold up head
_____ Sit up
_____ Cross Crawl
_____ Stand alone
_____ Walk alone

We are here to serve you and encourage you to ask questions and express concerns. Your participation is vital and will help determine your child's results. If you have any remaining questions, concerns, or information that this form did not cover, please use this space to write that:

_____

_____

_____

_____

_____

Authorization for Care of Minor

I hereby authorize this office and its doctors to administer care to my child as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees in this office.

Patient Name: _____

Name of Patients' Parent or Guardian: _____

Signature of Parent or Guardian: _____

Date: _____