**Patient (Child’s) Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s date: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Child’s Age: \_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Contact – Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pediatrician/ Family MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Visit: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Health Concern(s):**

Purpose of this visit: \_\_\_\_\_\_ Wellness Check-up \_\_\_\_\_\_ Injury or Accident \_\_\_\_\_\_ Other

Please explain current health concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this/these symptom(s) begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was there an accident or injury involved? Yes/No

Has your child ever had this before? Yes/No If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any medical or alternative treatment for this complaint? Yes/No

If so, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What were the results of the past treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all the medications your child has taken in the last 6 months:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any complications during pregnancy? Yes/No

Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were any medications taken during pregnancy? If so, what were they?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle if any birth interventions were used: Forceps Vacuum C-Section

Complications during delivery: Yes/No

Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any genetic disorders or disabilities?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child received vaccinations? Yes/No

Has your child had any of these diseases?

Chicken Pox: Yes/No Age: \_\_\_\_\_\_\_\_\_\_\_\_\_

Rubella: Yes/No Age: \_\_\_\_\_\_\_\_\_\_\_\_\_

Measles: Yes/No Age: \_\_\_\_\_\_\_\_\_\_\_\_\_

Mumps: Yes/No Age: \_\_\_\_\_\_\_\_\_\_\_\_\_

Whooping Cough: Yes/No Age:\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast Fed: Yes/No How long: \_\_\_\_\_\_\_\_\_\_

Formula Fed: Yes/No How long: \_\_\_\_\_\_\_\_\_\_

Food Allergies or Intolerances: Yes/No

Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been involved in any high impact or contact sports (i.e.: soccer, hockey, lacrosse, football, gymnastics, baseball, cheerleading, martial arts, etc)? Yes/No

Were any injuries involved with these sports? If so, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever been in a car accident? Yes/No

Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child experienced any of these traumas?

\_\_\_\_ Fall from bed \_\_\_\_ Fall from couch \_\_\_\_ Fall from crib \_\_\_\_ Fall off bicycle

Other traumas not described above? Yes/No

Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior surgeries? Yes/No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check if your child has had any of the following:**

\_\_\_\_ Headaches \_\_\_\_ Poor Posture \_\_\_\_ Growing Pains \_\_\_\_ Scoliosis

\_\_\_\_ Tonsillitis \_\_\_\_ Asthma \_\_\_\_ Torticollis \_\_\_\_ Ear Infections

\_\_\_\_ Seizures \_\_\_\_ Sleep Problems \_\_\_\_ Digestive Issues \_\_\_\_ Bedwetting

\_\_\_\_ Autism \_\_\_\_ ADD/ADHD \_\_\_\_ Frequent Fevers \_\_\_\_ Colic

\_\_\_\_ Learning Difficulties \_\_\_\_ Hip Dysplasia \_\_\_\_ Allergies \_\_\_\_Anemia

\_\_\_\_ Behavioral Problems \_\_\_\_Dizziness \_\_\_\_Poor Appetite \_\_\_\_\_ Fainting

\_\_\_\_\_Stomach Aches \_\_\_\_ Muscle Pain \_\_\_\_\_Heart Trouble \_\_\_\_\_Constipation

\_\_\_\_Diarrhea \_\_\_\_\_ Sinus Issues \_\_\_\_\_ Frequent Colds \_\_\_\_\_Walking Difficulties

How would you rate your child’s diet? \_\_\_\_ Well Balanced \_\_\_\_ Average \_\_\_\_ Poor

Sleep Quality: \_\_\_\_Good \_\_\_\_Fair \_\_\_\_Poor

During development, your child’s spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

**Authorization to Treat a Minor**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the parent/guardian having legal custody/guardianship of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a minor, do hereby authorize, request and direct Dr. Kelly Pflug to perform any chiropractic evaluations and adjustments that are deemed necessary.

The risks associated with chiropractic adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. I fully understand that I am responsible to Abundant Health Chiropractic LLC for all fees associated with care my child receives.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_