Select-Care Chiropractic
Dr. Sloane DeLuke Eusebio

2 Chelsea Place
Clifton Park, New York 12065
(Located at CareNet Medical Group)

Phone: (518) 373-6545
Fax: (518) 371-8102
E-mail: drsloane@hotmail.com

Child Health History Form

We are happy you have chosen to have your child's spine checked. Many types of stress (physical, mental, and chemical) can interfere with you child's growing spine and nervous system. Spinal health is an exciting new concept for many people, so please ask questions!

Child's Name_____ Date of Birth_____ Age____

Address_____ City/State_____ Zip_____

Home Phone_____ Parent's work phone _____

Mother's Name_____ Father's Name _____

Names and Ages of Siblings _____

Reason for consulting our office _____

Referred by _____

Previous Chiropractic Care? Y/N If yes, with whom? _____

How Long was care received?_____ Last Check-up_____

Circle Appropriately

Birth Place: Home/Birth Center/Hospital

Type: Vaginal/C-section

Procedures: Forceps/Vacuum Extraction

Was delivery long: Y/N Was delivery difficult? Y/N Labor Induced? Y/N

Epidural? Y/N Pain Medication? Y/N

Was baby breech/in utero-constraint? Y/N

Was baby breast fed? Y/N Duration_____

Which sports does/did your child participate in:

None/Soccer/Football/Gymnastics/Cheerleading/Karate/Basketball/Dance

Other(s)_____

According to the National Safety Council, approximately 54% of infants fall head first from a high place (bed, changing table, etc...) during the first year of life. Has this happened to your child? Y/N Comments_____

List any other falls or accidents_____

Check any of the following conditions your child has suffered from:
(Circle 'P' if in the distant past, circle 'R' if in the past 6 months)

P/R Ear Infections	P/R Scoliosis	P/R Seizures
P/R Chronic colds	P/R Asthma/Allergies	P/R Digestive Problems
P/R Headaches	P/R ADD/ADHD	P/R Recurring Fevers
P/R Growing/Back Pains	P/R Colic	P/R Bed Wetting
P/R Constipation	P/R Head Banging	P/R Other:_____

List date and year of any surgeries or hospitalizations _____

_____

MEDICATION

How many rounds of antibiotics has your child taken in the last 6 months?_____ Lifetime_____

Present prescription drugs_____

Past prescription drugs_____

Over the counter drugs (past 6 months) _____

FINANCIAL INFORMATION

Person responsible for account: _____

Are you planning to use some type of insurance? Y/N Type?_____

Social Security #?_____ I.D.#?_____

****

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize _____ and whomever they may designate to administer care as they deem necessary to my son/daughter.

Signed:_____ Witnessed:_____

Dated this _____ day of _____, _____.