NASHUA FAMILY CHIROPRACTIC

Brandon Linatsas, DC
Gabrielle Cohen, DC
Vicki Irwin, LAC
Candice Trudel, MS
Matthew Howard, LMT

29 Riverside Street, Unit B, Nashua, NH 03062 P: (603) 880-4150 F: (603) 880-6765

Welcome to Our Family! Your child's health history is important to us. Please fill out this form COMPLETELY.		
Today's Date:		
Patient First Name:	Patient Last Name:	
Parent/Guardian Name (s):		
Relationship to Patient:		
Street Address:		
City:	State:	Zip Code:
Home #:	Cell #:	Work #:
How would you like your future appointment reminders? ☐Call ☐ Text ☐No Reminder **Cell Phone Provider:**_____		
Email:		
Date of Birth: / /	Age:	Sex: ☐Female ☐Male
Emergency Contact Name:	Relationship:	
Emergency Contact Phone #: ( )	Secondary #: ( )	
Primary Care Provider:	Phone: ( )	
Primary Care Provider Address:		
Who may we thank for you referring you?		

What school/daycare does the patient attend:

If you know your child's approximate height and weight please specify here	Height: _____'_____"	Weight: _____lbs

Why are you seeking chiropractic care? ☐Pain ☐Wellness ☐Nutrition/Lifestyle ☐Other	
What is the area of complaint?	
When did the symptoms start?	

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Has your child experienced this before?	
Has school been missed due to this condition?	☐ No ☐ Yes How Long?
Is this condition due to an automobile accident?	☐ No ☐ Yes
Has your child been seen by another provider or received treatment for this condition?	☐ No ☐ Yes Whom?
Has there been any previous tests, x-rays, CT scans or MRI's previously taken?	☐No ☐ Yes What was done?
Has your child been checked by a doctor of chiropractic before?	☐ No ☐Yes Whom?

Medications/Allergies

Current Medications: Please list all prescriptions, over-the-counter medicines and dietary supplements. If possible, include the brand name for supplements. If NO current medications please check here ☐

Medication/Supplement	Dose	Frequency
1.		
2.		
3.		

Please list any known allergies your child may have. If no known allergies, check here ☐

1.	2.
3.	4.

Please check the following boxes if your child HAS or HAD any of the listed symptoms/conditions.

Cardiovascular	**Digestive**	**Endocrine**	**Integumentary**
☐No issues	☐No issues	☐No issues	☐No issues
☐Heart Defect	☐Reflux/GERD	☐Diabetic ☐Type I ☐Type II	☐Psoriasis
☐Excessive Bruising	☐Colic	☐Swollen glands	☐Eczema
☐Palpitations	☐Constipation	☐Other	☐Acne
☐Asthma	☐Diarrhea	**Developmental**	☐Rash
☐Persistent cough	☐Food Sensitivities	☐Delayed Speech	☐Birth marks

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☐Mouth-breather	☐Poor Appetite	☐Delayed gross motor skills	☐Other
☐Congestion	☐Anorexia/ Bulimia	☐Delayed fine motor skills	
☐Bronchitis/Pneumonia	☐Other	☐ Delayed social skills	
Immune	**Constitutional**	**Musculoskeletal**	**Neurological**
☐No issues	☐Lethargic	☐Joint/Bone pain	☐Dizziness
☐Chronic colds	☐Difficulty sleeping/ Irregular sleep patterns	☐Growing pains	☐Balance/Coordination Issues
☐Laryngitis/Tonsilitis			
☐Ear & Sinus Infections	☐Bed-wetting	☐Headaches	☐Epilepsy/Seizures
☐Low Energy	☐Pre-mature birth	☐Developmental Delays	☐ Visual/hearing issues
☐ UTI's			
☐Other	☐PTSD	☐ Torticollis	☐ADD/ADHD
	☐Other	☐ Scoliosis	☐Autism Spectrum
		☐ Abnormal Walk	☐Focus/Memory Issues
		☐TMJ/Jaw pain	☐Speech Issues
		☐Poor Posture	☐Anxiety/Depression
		☐Other	☐Other

Daily Habits	
How much exercise does your child get?	
How much time does your child spend watching TV or a screen?	About_____ hrs. per day
What sports or activities does your child participate in?	☐My child doesn't engage in sports/activities ☐Yes, my child plays…
What position does your child sleep in? **How much sleep are they getting a day?**	☐Back ☐Side ☐Stomach _____ hrs.
What is a typical breakfast for your child?	

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How would you rate their diet?	☐Poor ☐Fair ☐Healthy ☐Very Healthy

Please date/list reasons for any hospitalizations or surgical procedures.

Date	Reason

Please describe any other injuries/accidents not mentioned previously.

Date	Injury

Are there any past or current medical conditions you have not told us about?

Is there anything additional we should know about your child?

Family History

Please include any pertinent, immediate family medical histories (Diabetes, hypertension, cardiac arrest, stroke, cancer, rheumatoid arthritis etc.)

Parent/Guardian Signature:_____ Date: _____