



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?		
<input type="checkbox"/> Call <input type="checkbox"/> Text <input type="checkbox"/> No Reminder		
Cell Phone Provider: _____		
Email:		
Date of Birth: / /	Age:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other _____
Emergency Contact Name:		Relationship:
Emergency Contact Phone #: ()		Secondary #: ()
Primary Care Provider:		Phone: ()
Primary Care Provider Address:		
<input type="checkbox"/> Please do not share results of this visit with this provider		
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? <input type="checkbox"/> Pain <input type="checkbox"/> Wellness <input type="checkbox"/> Nutrition/Lifestyle <input type="checkbox"/> Other		
What is the area of complaint?		
When did the symptoms start?		



29 Riverside Street, Unit B, Nashua, NH 03062

P: (603) 880-4150

F: (603) 880-6765

Has your child experienced this before?	
Is this condition due to an automobile accident?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Has your child been seen by another provider or received treatment for this condition?	<input type="checkbox"/> No <input type="checkbox"/> Yes Whom?
Has there been any previous tests, x-rays, CT scans or MRI's previously taken?	<input type="checkbox"/> No <input type="checkbox"/> Yes What was done?
Has your child been checked by a doctor of chiropractic before?	<input type="checkbox"/> No <input type="checkbox"/> 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.

Prenatal History

Is your child adopted?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Was your child conceived naturally or with assisted reproductive technology?	<input type="checkbox"/> Natural <input type="checkbox"/> Assisted
Were there any complications during pregnancy or birth?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Did you smoke?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Did you consume alcohol?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Were you taking any medications?	<input type="checkbox"/> No <input type="checkbox"/> Yes, I took _____



29 Riverside Street, Unit B, Nashua, NH 03062

P: (603) 880-4150

F: (603) 880-6765

Place of birth:	Provider:
Type of birth: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section <input type="checkbox"/> Water birth	
Were pain medications used? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Was labor induced? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Was your child malpositioned during birth? Breech, etc. <input type="checkbox"/> No <input type="checkbox"/> Yes	
Were there any interventions? <input type="checkbox"/> Doctor/Midwife assisted <input type="checkbox"/> Twisting/pulling <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum Extraction	
Did/do you breast feed your child? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, for how long? _____	
Did/does your child prefer one breast over the other? <input type="checkbox"/> No <input type="checkbox"/> Yes- <input type="checkbox"/> Right <input type="checkbox"/> Left	

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

Cardiovascular	Digestive	Endocrine	Integumentary
<input type="checkbox"/> Heart Defect	<input type="checkbox"/> Reflux/GERD	<input type="checkbox"/> Diabetic <input type="checkbox"/> Type I <input type="checkbox"/> Type II	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Excessive Bruising	<input type="checkbox"/> Colic	<input type="checkbox"/> Swollen glands	<input type="checkbox"/> Eczema
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Constipation	<input type="checkbox"/> Other	<input type="checkbox"/> Acne
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diarrhea	Developmental	<input type="checkbox"/> Rash
<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Food Sensitivities	<input type="checkbox"/> Delayed Speech	<input type="checkbox"/> Birth marks
<input type="checkbox"/> Mouth-breather	<input type="checkbox"/> Poor Appetite <input type="checkbox"/> Tongue/Lip Tie	<input type="checkbox"/> Delayed gross motor skills	<input type="checkbox"/> Other
<input type="checkbox"/> Congestion	<input type="checkbox"/> Other	<input type="checkbox"/> Delayed fine motor skills	
<input type="checkbox"/> Bronchitis/Pneumonia		<input type="checkbox"/> Delayed social skills	
<input type="checkbox"/> Other		<input type="checkbox"/> Other	
Immune	Constitutional	Musculoskeletal	Neurological
<input type="checkbox"/> Chronic colds	<input type="checkbox"/> Lethargic	<input type="checkbox"/> Joint/Bone pain	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Laryngitis/Tonsillitis	<input type="checkbox"/> Difficulty sleeping/ Irregular sleep patterns	<input type="checkbox"/> Growing pains	<input type="checkbox"/> Balance/Coordination Issues
<input type="checkbox"/> Ear & Sinus Infections			
<input type="checkbox"/> Low Energy	<input type="checkbox"/> Bed-wetting	<input type="checkbox"/> Headaches	<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/> UTI's	<input type="checkbox"/> Pre-mature birth	<input type="checkbox"/> Developmental /Motor Skill Delays	<input type="checkbox"/> Visual/hearing issues
<input type="checkbox"/> Other			



**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

	<input type="checkbox"/> PTSD	<input type="checkbox"/> Torticollis	<input type="checkbox"/> ADD/ADHD
	<input type="checkbox"/> Other	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Focus/Memory Issues
		<input type="checkbox"/> Abnormal Walking	<input type="checkbox"/> Speech Issues
		<input type="checkbox"/> Poor Posture	<input type="checkbox"/> Anxiety/Depression

Daily Habits	
How much exercise does your child get?	
Does your child use a Johnny jump up, bumbo or any other sit/stand-assist?	
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?	<input type="checkbox"/> My child doesn't engage in sports/activities <input type="checkbox"/> Yes, my child plays...
What position does your child sleep in?	<input type="checkbox"/> Back <input type="checkbox"/> Side <input type="checkbox"/> Stomach How much sleep are they getting a day? _____ hrs.
What is a typical breakfast for your child?	
How would you rate their diet?	<input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Healthy <input type="checkbox"/> 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?	



**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

--

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: _____