



NASHUA FAMILY CHIROPRACTIC

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

Mission: "To raise the vibration of everyone who walks through our door."
Vision: "To revolutionize healthcare in our community."

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 #:
Would you like us to send you a text message for your future appointment reminders?		
<input type="checkbox"/> Yes, Text Please! <input type="checkbox"/> No Thank you, No Reminder needed.		
If yes, what is your Cell Phone Carrier? _____		
Email:		
Date of Birth: / /	Age:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male
Emergency Contact Name:		Relationship:
Emergency Contact Phone #: ()		Secondary #: ()
Primary Care Provider:		Phone: ()
Primary Care Provider Address:		
Who may we thank for 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
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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?	



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Has your child experienced this before?	
Has school been missed due to this condition?	<input type="checkbox"/> No <input type="checkbox"/> Yes How Long?
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.

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

Cardiovascular	Digestive	Endocrine	Integumentary
<input type="checkbox"/> No issues	<input type="checkbox"/> No issues	<input type="checkbox"/> No issues	<input type="checkbox"/> No issues
<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"/> Delayed gross motor skills	<input type="checkbox"/> Other
<input type="checkbox"/> Congestion	<input type="checkbox"/> Anorexia/ Bulimia	<input type="checkbox"/> Delayed fine motor skills	



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<input type="checkbox"/> Bronchitis/Pneumonia	<input type="checkbox"/> Other	<input type="checkbox"/> Delayed social skills	
Immune	Constitutional	Musculoskeletal	Neurological
<input type="checkbox"/> No issues	<input type="checkbox"/> Lethargic	<input type="checkbox"/> Joint/Bone pain	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Chronic colds	<input type="checkbox"/> Difficulty sleeping/ Irregular sleep patterns	<input type="checkbox"/> Growing pains	<input type="checkbox"/> Balance/Coordination Issues
<input type="checkbox"/> Laryngitis/Tonsilitis			
<input type="checkbox"/> Ear & Sinus Infections	<input type="checkbox"/> Bed-wetting	<input type="checkbox"/> Headaches	<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/> Low Energy	<input type="checkbox"/> Pre-mature birth	<input type="checkbox"/> Developmental Delays	<input type="checkbox"/> Visual/hearing issues
<input type="checkbox"/> UTI's			
<input type="checkbox"/> Other	<input type="checkbox"/> PTSD	<input type="checkbox"/> Torticollis	<input type="checkbox"/> ADD/ADHD
	<input type="checkbox"/> Other	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Autism Spectrum
		<input type="checkbox"/> Abnormal Walk	<input type="checkbox"/> Focus/Memory Issues
		<input type="checkbox"/> TMJ/Jaw pain	<input type="checkbox"/> Speech Issues
		<input type="checkbox"/> Poor Posture	<input type="checkbox"/> Anxiety/Depression
		<input type="checkbox"/> Other	<input type="checkbox"/> 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?	<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? How much sleep are they getting a day?	<input type="checkbox"/> Back <input type="checkbox"/> Side <input type="checkbox"/> Stomach _____ 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



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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: _____