

**Dr. Leilani Bettencourt, B.S., D.C., C.C.P.**

PLEASE PRINT

Child's Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

Child's SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Parent Email Address(es): \_\_\_\_\_

Parent #1 Name: \_\_\_\_\_ Work /Cell Phone #: \_\_\_\_\_

Parent #2 Name: \_\_\_\_\_ Work /Cell Phone #: \_\_\_\_\_

Insured Parent's SSN: \_\_\_\_\_ Insured Parent's Date of Birth: \_\_\_\_\_

**BIRTH INFORMATION**

Type of Birth: Vaginal  Forceps  Breech  Cesarean  Home  Birthing Center  Hospital

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ Apgar Scores: \_\_\_\_\_

At Birth: Jaundice (yellow)?  YES  NO Cyanosis (blue)?  YES  NO

Medication taken during pregnancy? \_\_\_\_\_ Epidural:  YES  NO

Any problems during pregnancy and/or labor? \_\_\_\_\_

Congenital Anomalies/Defects: \_\_\_\_\_

Infant Feeding: Breast  Bottle  Formula  Other Food or Drink Information: \_\_\_\_\_

No. of Hours Child Sleeps Daily \_\_\_\_\_ Quality of Sleep: Good  Fair  Poor

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

Number of Siblings \_\_\_\_\_ Siblings Name, Age and Sex \_\_\_\_\_

**ADOPTION INFORMATION**

Child's Age When Adopted \_\_\_\_\_ Date of Adoption \_\_\_\_\_

Known Health History of Child \_\_\_\_\_

**MEDICAL INFORMATION**

Obstetrician and/or Midwife Name: \_\_\_\_\_ Location: \_\_\_\_\_

Pediatrician and/or Family MD Name: \_\_\_\_\_ Location: \_\_\_\_\_

Date of Last Visit to Dr: \_\_\_\_\_ Purpose of that Visit: \_\_\_\_\_

Immunization History: \_\_\_\_\_

Has your child ever been treated on an emergency basis? \_\_\_\_\_ Please Describe: \_\_\_\_\_

# HEALTH INFORMATION

Purpose of the appointment today with the Chiropractor: \_\_\_\_\_

Pregnancy History: \_\_\_\_\_

Delivery/Birth History: \_\_\_\_\_

**Developmental History – At What Age Did the Child:**

Respond to Sound \_\_\_\_\_  
Crawl \_\_\_\_\_  
Follow an Object with their Eyes \_\_\_\_\_  
Hold Head Up \_\_\_\_\_  
Stand \_\_\_\_\_  
Sit Alone \_\_\_\_\_  
Walk Alone \_\_\_\_\_

**Childhood Diseases – Age of the Child When Occurred:**

Chicken Pox \_\_\_\_\_  
Rubella \_\_\_\_\_  
Rubeola \_\_\_\_\_  
Whooping Cough \_\_\_\_\_  
Mumps \_\_\_\_\_  
Measles \_\_\_\_\_  
Other \_\_\_\_\_

Has this child ever suffered from (please check any that apply):

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Bed Wetting         | <input type="checkbox"/> Convulsions      | <input type="checkbox"/> Neck Problems       |
| <input type="checkbox"/> Fainting                | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Backaches        | <input type="checkbox"/> Heart Trouble       |
| <input type="checkbox"/> Dizziness               | <input type="checkbox"/> Stomach Aches       | <input type="checkbox"/> Allergies        | <input type="checkbox"/> Orthopedic Problems |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Walking Problems    | <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Hypertension        |
| <input type="checkbox"/> Sugar Concentration     | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Blood Disorders  | <input type="checkbox"/> Broken Bones        |
| <input type="checkbox"/> Sleeping Problems       | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Sinus Trouble    | <input type="checkbox"/> Leg Problems        |
| <input type="checkbox"/> Diarrhea                | <input type="checkbox"/> Constipation        | <input type="checkbox"/> Paralysis        | <input type="checkbox"/> Joint Problems      |
| <input type="checkbox"/> Arm Problems            | <input type="checkbox"/> Hyperactivity       | <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Colds/Flu           |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Neuritis            | <input type="checkbox"/> Anemia           | <input type="checkbox"/> Poor Appetite       |
| <input type="checkbox"/> Behavioral Problems     | <input type="checkbox"/> Muscle Jerking      | <input type="checkbox"/> Ruptures/Hernias | <input type="checkbox"/> "Growing Pains"     |
| <input type="checkbox"/> Any Other Problem _____ |  |   |  |

Present Health History or Additional Information: \_\_\_\_\_

Surgery Information: \_\_\_\_\_

Medications: \_\_\_\_\_

Accidents: \_\_\_\_\_

Family Health History: \_\_\_\_\_

***The statements made on this form are accurate to the best of my knowledge.***

Signature \_\_\_\_\_

Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_