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):

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

• 1620 Westwood Dr. Suite D • San Jose, CA 95125 • 408.448.0505 • Fax 408.448.0504