LIFE CHIROPRACTIC CENTER
NEURO BEHAVIORAL
CONFIDENTIAL PATIENT INFORMATION

Date: _____ E-Mail Address _____
Full Name: _____
Name of Parent or Guardian: _____
Address: _____
City_____ State _____ Zip Code _____

Telephone Number ( )_____ Cell Phone Number ( ) _____ ____
Social Security No.____--____--____
Birthdate: _____
Name and address of Nearest Relative: _____
_____
(Not living with you)

How did you hear about our office? _____

List Chiropractors you have seen before:

1. Name: _____
   When: _____
   _____
2. Name:_____
   When _____

List Medical Doctors consulted within the past year:

1. Name: _____ Address: _____
   When: _____ Reason for visit? _____
2. Name: _____Address: _____
   When: _____ Reason for visit? _____

All Current Medications _____
_____

List your child's developmental disorder according to severity	Date parent 1st noticed symptom	Date Diagnosed	Is disorder getting better or worse?
1._____			
2._____			
3._____			

1. Specific goals you as a parent want to see:
   Improve
   _____
   Behaviors you do not want to see
   anymore_____

2. Have any other family members been diagnosed with Autism Spectrum Disorders, ADD, ADHD, or Dyslexia?
   Yes _____ No _____ If yes, please list relationship
   _____

3. Have any other family members been diagnosed with Autoimmune Disease, Rheumatoid Arthritis, Lupus, Scleroderma, MS, ALS, Thyroid Disease, Autoimmune Diabetes, Grave's, other?
   _____ Yes _____No If yes, please list relationship
   _____

4. <u>Mom's Health During Pregnancy</u>
   Was mom overweight? Yes _____ No _____ If yes, weight
   _____
   Was mom sick? Yes _____ No _____ Name illness
   _____
   How many births has the mother had?
   _____
   How many miscarriages?
   _____
   Did mom use fertility drugs? Yes _____ No_____
   Health of siblings
   _____
   Maternal stress during pregnancy: divorce? Yes ____ No ____; car accident? Yes ____ No___
   physical trauma? Yes ____ No ____; broken bones? Yes ____ No _____;
   death in family? Yes ____ No ____; job loss? Yes ____ No ____ if yes, explain
   _____
   _____

   Mom's exposure to toxins (example: mold, pesticides) Yes _____ No _____ if yes, explain
   _____
   Known infection(s) mom had during pregnancy
   Yeast? _____; bacterial? _____; viral? _____
   Did mom drink alcohol during pregnancy? Yes ____ No ____; smoke? Yes ____ No ____;
   drink coffee? Yes ____ No ____; excessive bleeding? Yes ____ No ____; vomiting? Yes ____
   No ____

5. <u>Birthing Process</u>
   What type of delivery?
   _____
   Any birth trauma? Yes _____ No _____ if yes, explain
   _____
   _____
   _____

Was delivery induced? Yes _____ No _____ Natural? Yes _____ No _____ Epidural? Yes ___ No ____
APGAR score _____ at one minute _____ at 5 minutes

6. Infant toxic exposure
   Mold in house? Yes _____ No _____; pesticide? Yes_____ No _____; other _____

7. Infections
   Name all infections first two years of child's life:
   _____Age of onset _____; _____ Age of onset ____
   _____ Age of onset _____; _____ Age of onset ____
   _____ Age of onset _____; _____ Age of onset ____
   Is child on antibiotics now? Yes _____ No _____
   At what age did child first start antibiotics? _____ What age was the first illness?_____

8. Please list **ALL** surgeries and child's age at time of surgery:
   _____
   _____
   _____
   _____

9. What kinds of discipline do the child's parents/guardians use? None_____, Don't know_____
   yelling_____, lectures_____, physical punishment_____, grounding_____, loss of allowance/privileges_____

   How strict are the child's parents/guardians? Don't know_____, very strict_____, strict _____, average____, permissive_____, very permissive_____

   Has the child ever been abused by a current or previous member of the household?
   does not apply_____, do not know_____ ,No____, Yes____, physically_____
   emotionally_____, verbally _____, sexually _____, neglected_____

10. Motor Development
    Child's age when first held head up ____; rolled over ____; sat up ____; crawled ____; walked _____
    Did child display any "cute" or out of the ordinary behavior when learning to crawl or walk?
    Yes _____ No _____ if yes, explain
    _____
    _____
    _____

Age potty trained: _____ age stopped wetting bed: _____ age of first words “mama”, “dada” _____
Age child spoke 2 to 3 words together _____

Has child lost language? Yes _____ No _____; if yes, what age and how far did they regress? _____
_____
How many words was your child using in a sentence before regression?
_____
Has child lost eye contact? Yes _____ No _____; if yes, at what age:
_____
How long did mother breast feed? Months _____ Never _____
Age child started bottle-feeding? _____; formula? Yes ____ No ____; soy based? Yes ____ No _____
casein based? Yes _____ No _____
Age cow’s milk was introduced _____; age wheat & grains were introduced?
_____

11. Vaccine Response
Seizures? Yes _____ No _____ When did seizures start? _____ How long did they last?
_____
Bowel symptoms? Yes _____ No_____, if yes, explain
_____
Swelling at injection site? Yes _____ No _____ Fever? Yes _____ No _____

12. Current Diet
What is your child eating now? Look back over past 3 days and be as accurate as possible.
_____
_____
_____
_____

Does your child refuse to eat certain foods? Yes ____ No____; which foods? _____
_____

List all sweets that your child eats:_____
_____

How many glasses of milk does your child drink per day?_____
How much cheese consumption per day? _____ Slices of bread per day?_____
How many sodas per day? _____
How many glasses of fruit juice? _____ How many sports drinks per day? _____
Does your child eat salty food or crave salty food? Yes _____ No _____
Fast food meals per day? _____ Meat intake per day? _____ ounces; What type? _____
Veggies per day? _____

13. GI Tract

How many bowel movements per day? _____ Is your child constipated? Yes ____ No _____
Bloating? Yes _____ No _____ Dark circles under eyes? Yes ___ No ___
Is your child's behavioral symptoms worse during ____damp; ___hot; ___misty; ___moldy; ____other
weather?
Does your child wake up at night laughing or giggling? Yes ____ No ____
Does your child put pressure on stomach? Yes ____ No _____