MINDSPRING CENTER
A RANICKI COMPANY

Date: ____/____/____

Child's Name _____ Birth Date ____/____/____ Age _____ Male ___ Female ___

SS # _____ Parent's Names _____

Address _____
Street City State Zip Code

Home Telephone # _____ Alternate Telephone # _____(c) (w)

Email address_____ Emergency Contact and number _____

Do you have: Medicare Medicaid Private Insurance TriCare

Who may we thank for referring your child to our office? _____

Primary Care Provider/Pediatrician _____

HEALTH PROFILE

What brings your child to our office? _____
_____
_____
_____

How do these problems affect your child's quality of life? _____
_____

What things do these problems prevent them from doing or make them do that they otherwise would or would not do? _____
_____
_____

Neurological Challenges can come from the birth process itself. Please tell us about your child's delivery.

Was your Child full term? ____ Premature? How long? _____Past expected due date? How long? _____
Were Forceps ____ Vacuum Extraction _____ or a C-Section _____ necessary?
Is there anything else about the delivery you would like to tell us? _____

Feeding History

Was your child breast fed? _____ For how long? _____
Was your child formula fed? _____ For how long? _____
At what age were solid foods introduced? _____

Possible Injuries

50% of all children fall or are dropped from a high place during the first year of life. Has your child ever fallen from the bed, bunk bed, changing table, down the stairs, a tree, etc.? ____ Describe _____
Has your child ever been in the car with anybody during a collision, regardless of how minor? _____
Does your child play any contact sports? _____

History of Illnesses

Does your child have a history of chronic ear infections? _____ how many in how long? _____
What treatments has (s)he received for this? Antibiotics _____ Tubes _____ Myringotomy _____ Other _____
Does the child have a history of chronic Tonsillitis? _____ If so, have the tonsils been removed? _____
Does the child have a history of Appendicitis? _____ If so, has the Appendix been removed? _____
Has your child had any other surgeries? _____
Has your child ever seen an alternative healthcare provider before? Yes No If yes - Who? _____
Where? _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine my child for further evaluation. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

_____ _____
Signature Date