

WINCHESTER HOSPITAL CHIROPRACTIC CENTER



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Baldwin Park II
Woburn, MA 01801
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Dr. Heidi Henrickson
Dr. Lee Zohn
Dr. Gary Kane



We are excited you are here. We offer a unique service to individuals and families. We will make every effort to make your experience supportive, informative and healing.

Child's Name _____ Parent's Names _____

Child's Date of Birth _____ Age _____ M / F Height _____ Weight _____

Address _____ Home Phone (_____) _____

Name of child's pediatrician and location _____ Can we contact them if needed _____

Who told you about our office _____ Reason for today's visit _____

BIRTH MOTHER'S PREGNANCY

Did the mother have any injuries during the pregnancy (accidents, falls, etc.) _____

Any treatment required during the pregnancy (chiro., PT, massage, etc.) _____

Any health problems during the pregnancy (diabetes, pre-eclampsia, bed rest, etc.) _____

Any medications or drugs taken during the pregnancy _____ Did the mother smoke _____

LABOR AND DELIVERY

Problems during labor and delivery _____

Type of birth: Vaginal _____ C-Section _____ Forceps _____ Vacuum Extraction _____ Home Birth _____

Name of Hospital/Delivery Center _____ Was a Midwife or Doula used _____

Length of Labor _____ Length of Delivery (pushing) _____ Did the mother have an epidural _____

Baby's birth weight _____ Birth length _____ APGAR Scores _____ Length of Hospital stay _____

Problems with the baby after delivery _____

CHILD'S HEALTH HISTORY

Health problems with the child now or in the past _____

Accidents or injuries to the child (falls, car, sports, broken bones) _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their 1st year of life (i.e. a bed, changing table, down stairs, etc.). Was this the case with your child? No Yes

Was the child breast fed _____ If so, for how long _____ Was the child bottle fed _____ For how long _____

Current milk: Breast _____ Formula/Type _____ Cow's milk-what % _____ Soy milk _____ Rice milk _____

Frequency of eating _____ Current food/snacks _____

Any known food or environmental allergies/intolerances _____

Current medications _____ Current behavior _____

Number of hours of sleep per night _____ Quality of sleep: Good _____ Fair _____ Poor _____

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

GENERAL SYMPTOMS Check symptoms the child currently has or has had in the past year

GENERAL

- ADD/ADHD
- Allergies
- Autism/Asperger's
- Anemia
- Bed Wetting
- Behavioral Problems
- Bladder Infection
- Broken Bones
- Cancer/Tumors
- Depression
- Diabetes
- Difficulty Sleeping
- Dizziness
- Dyslexia
- Epilepsy
- Fainting
- Growing Pains
- Heart Problems
- Hodgkin's Lymphoma
- Hyperactivity
- Juvenile Arthritis
- Nightmares
- Night Sweats
- Paralysis
- PDD
- Seizures
- Speech Problems
- Stroke

EYE, EAR, NOSE & THROAT

- Pink Eye
- Vision Problems
- Dizziness
- "Crossed" Eyes
- Ringing in Ears
- Hearing Loss
- Earache
- Ear Infections
- Nose Bleeds
- Sinus Problems
- Bad Breath
- Colds-Flu
- Frequent Runny Nose

RESPIRATORY

- Asthma
- Bronchitis
- Pneumonia
- Mononucleosis
- Shortness of Breath
- Cough/Wheeze

GASTRO-INTESTINAL

- Poor Appetite
- Excessive Appetite
- Bloating/Gas
- Indigestion
- Nausea
- Reflux
- Constipation
- Diarrhea
- Colitis/IBS
- Hernia

HEAD, NECK and SPINE

- Headaches
- Neck Pain
- Neck Stiffness
- Torticollis
- Midback Pain
- Low back Pain
- Back Spasms
- Scoliosis
- Muscle/joint pain

ARMS and HANDS

- Shoulder Pain
- Broken Collar Bone
- Erb's Palsy
- Elbow Pain
- Dislocated Elbow
- "Little League Elbow"
- Wrist or Hand Pain
- Numbness or Tingling in arms

HIPS, LEGS and FEET

- Buttocks Pain
- Hip Pain
- Congenital Hip Dysplasia
- Knee Pain
- Ankle or Foot Pain
- Toes turn in or out
- Bow Legs or Knock Knees
- Walks on Toes
- Flat Feet
- Limp

SKIN

- Eczema
- Psoriasis
- Hives
- Rash
- Bumps on back of arms or legs
- Dark circles under eyes or puffiness

CHILDHOOD ILLNESSES

- Chicken Pox
- Colic
- Croup
- Diphtheria
- Measles
- Mumps
- RSV
- Rubella
- Tetanus
- Whooping Cough

OTHER:

Authorization for care of a minor: I hereby authorize Winchester Hospital Chiropractic Center and its doctors to administer care as they deem necessary to my son/daughter/ward. I accept responsibility for payment for services rendered.

Signature _____ Relationship _____ Today's Date _____

Witnessed _____ Today's Date _____