VITAL ROOTS
CHIROPRACTIC

Pediatric Name _____ Date _____ DOB _____
Gender _____ Height _____ Weight _____
Address _____
Parents Names: _____Parents Phone: _____
Parent's email address: _____
Has the child had chiropractic care before? Y N Doctors Name: _____

Prenatal and Delivery History
Chiropractic care through pregnancy? Y N _____
Any trauma or possible toxic exposure during pregnancy? _____
Gestation of pregnancy _____ Type of Delivery: Vaginal - C-Section - Breech
Complications during delivery (forceps, vacuum, cord problems, etc. _____
_____
List any concerns at birth (nursing, breathing, color, etc.) _____
_____

Pediatric History:
Breastfed? Y N Duration_____ Formula – type & when started_____
Solid food began age _____ Food intolerance? Y N Type:_____
Typical sleep patterns (day / night)_____
Age when started: Teething_____ Rolling_____ Crawling_____ Walking_____ Climbing_____
Babbling/Talking_____
List any immunizations / any reactions observed: _____

Reason for Care:
Concerns: _____
Date of onset _____ How did symptoms start? _____
What makes the concern better? _____
What makes the concern worse? _____

Authorization to Treat Minors I, _____, give my consent to Dr. Cassandra C Almeida, DC to evaluate and treat my son/daughter,

Signature: _____ Date:_____
Doctors Signature: _____ Date: _____