Dr. Jason Schilder
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New Berlin, WI 53151

Confidential Patient Information

Name: ____ Date of Birth ____/____/____ Age ____ Sex: M F

Address ________________________________ City __________________ State _____________ Zip ______

Home Phone ___________________ Work Phone ___________________ Cell Phone ___________________

Emergency Contact Name ___________________ Emergency Contact Phone Number ________________

Pediatrician: ___________________ Phone Number ______________ May we contact them? ☐ Yes ☐ No

Primary health concern that brings you to a chiropractor? ____

____

When did this begin? ____

Are the current issues due to an injury? ☐ Yes ☐ No Date of injury ____/____/____

How did you hear about our office? ____

How would you like us to handle your problem? ☐ Resolve Existing Condition OR ☐ Overall wellness

Had past chiropractic care? ☐ Yes ☐ No When? ____________

Please list all surgeries, falls, auto accidents and injuries (regardless how severe) with dates:

____

____

Medications:

Please list all prescription and over the counter medications

Name	Purpose	Dosage

Please list all known allergies ____

HEALTH CONCERNS – Please mark all that apply (past or present)

☐ Colic/Excessive Crying
☐ Torticollis
☐ Plagiocephaly
☐ Chronic Colds/Cough
☐ Ear/Sinus Infection
☐ Allergies
☐ Asthma
☐ Chronic Congestion
☐ Reflux/GERD
☐ Constipation
☐ Diarrhea
☐ Bedwetting
☐ Gas Pain/Bloating
☐ Bladder/Urination Issues
☐ Skin Conditions/Eczema
☐ Nausea/Vomiting
☐ Epilepsy/Seizures
☐ ADD/ADHD
☐ Speech Challenges
☐ Sensory Processing Disorder
☐ Difficulty Sleeping
☐ Anxiety
☐ Depression
☐ Autism/Asperger's

Other:____

PREGNANCY HISTORY: (if yes to any of the following, please explain)

Fertility issues? ____

Any smoking or drinking? ____

Any exercising? ____

Notable physical or emotional stress? ____

Any illness while pregnant? ____

LABOR/DELIVERY HISTORY:

Delivery: ☐ Difficult ☐ Vaginal ☐ Scheduled C-Section ☐ Emergency C-Section ☐ Forceps ☐ Premature delivery ☐ Vacuum

How long were you in labor? ________________________

Complications: ☐ Breech ☐ Epidural ☐ Induced

Baby's height and weight at birth: ____

POSTNATAL HISTORY:

Breastfed? __________ If yes, how long? _____________

Formula fed? _________ If yes, how long and what type? _____________

At what age did you introduce: Solids? _________________ Cow's milk? ____________________

Has your child received any antibiotics? ____________

If so, what for and how many rounds? ____

Did/does your child frequently arch their back or bang their head? __________

If so, explain: ____

Is your child vaccinated? ______________ If yes, any vaccine reactions? ______________________________

REASON FOR CARE:

Biggest health concern: ____

When did it begin?____

Is it getting better or worse?____

What makes the problem better?____

What makes the problem worse? ____

Worse during (circle): morning afternoon evening during sleep

What care have you received for this condition: ____

What is this affecting that is most important in your child's life? ________________________________

____

What are your top 3 health goals for your child?

1) ____

2) ____

3) ____