Dr. Mark Haynes
670 King Park Drive Ste 1
Billings, MT 59102
406-655-4940

Personal Information

NAME: ______________________________ AGE: __________

PARENT'S/GUARDIAN'S NAMES: ______________________________

ADDRESS: ______________________________

CITY: ______________________________ STATE: ________ ZIP: ________

MALE FEMALE

SOCIAL SECURITY #: ______________________________ BIRTHDATE: ______________

HOME PHONE #: ______________________________ CELL PHONE #: ______________

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE: ______________________________

Health Profile

Please briefly describe your chief concerns:

____

____

____

When did it begin? ______________________ Is it getting worse? □No □Yes

How often does the complaint affect daily activities/routines: □Not at all □ Sometimes □Frequently □Always

General History

Does your child have any food or other allergies? (list) ______________________________

Has your child been immunized according to the recommended schedule? □No □Yes

Did your child have any reactions to vaccinations? □No □Yes, was it reported? □No □Yes

Has your child ever had any surgeries □No □Yes, please explain ______________________________

Has your child ever been on antibiotics □No □Yes, how many times? _____ reason(s): ______________

Is your child currently taking any medications? □No □Yes, list ______________________________

Is your child currently taking any vitamins? □No □Yes, list ______________________________

Does your child participate in any sports? □No □Yes, □Soccer □Football □Gymnastics □Karate □Hockey

□Basketball □Dance □Wrestling □Baseball/softball □Volleyball □Tennis □Swimming □Running □Other ________

How would you rate your child's diet: □Well balanced □Average □High amounts of processed foods/sugar

Does your child consume artificial sweeteners? □No □Yes Fluoridated water? □No □Yes

Number of hours your child sleeps? ________/night Quality of sleep: □Good □Fair □Poor

Prenatal History

Is your child adopted: □No □Yes

Did mom have any complications? □No □Yes, when ______________________________

Did mom smoke/consume alcohol? □No □Yes

Did mom take any medication(s)? □No □Yes, reason ______________________________

Birth History

Did mom have an ultrasound during pregnancy? □No □Yes, frequency ____________________

Place of birth: □Home □Birthing Center □Hospital

Type of birth: □Vaginal □C-Section

Were pain medications used? □No □Yes

Was labor induced? □No □Yes, why ____________________

What position did you deliver in? □Squatting □On back □Other ____________________

Birth Trauma: □Doctor assisted □Twisting and/or pulling □Vacuum extraction □Forceps

Newborn trauma (medical procedures and tests): ____________________

APGAR score: at birth ___/1- at 5 minutes ___/10 □Unsure

Did your child have a misshapen skull/head? □No □Yes

Did your child have purple marking on their face? □No □Yes

Baby/Toddler (0-4)

Did mom/does mom breastfeed? □No □Yes for how long? ____________________

Does your child prefer one breast/side over the other? □No □Yes Side: □ Right □Left

Have/did any of the following occur:

□Fall from a changing table
□Frequent fevers
□Sleeping problems
□Fall out of crib
□Frequent bouts of diarrhea
□Constipation
□Car accident
□Repeated infections or colds
□Colic
□Fall of off playground equipment
□Frequent ear infections
□Inadequate weight gain
□Play in a Johnny jumper
□Tonsillitis

Child (5-12)

Have/did any of the following occur:

□Fall from a tree
□Fall on playground
□Learning disabilities
□Fall off bicycle
□Hyperactivity/autism
□Asthma
□Sports accident
□Bedwetting
□Scoliosis
□Car accident
□Stomach pains
□Leg/knee pain

Is there anything else we should know about your child? ____________________

____

Authorization to Treat a Minor

I, ____________________ the undersigning parent/person having legal custody/guardianship of ____________________, a minor, do hereby authorize, request and direct Dr Mitchell and whomever he may designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

PATIENT: ____________________

Name (Print)

SIGNATURE ____________________ DATE: ____________________

Parent/Legal guardian