Dr. John Bellomo
Director

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PEDIATRIC INFORMATION (*PLEASE PRINT CLEARLY)*

Date: _____

Child's First Name, M.I., and Last Name:_____

Delivery at: _____ Hospital _____ Birthing Center _____ Home Hours of Labor: _____

Is your child taking any medication? Yes No If yes, please list: _____

What is the reason for your child's visit? (Check all that apply)

( ) Asthma	( ) ADD/ADHD	( ) Allergies	( ) Aspergers
( ) Cough	( ) Constipation	( ) Colic	( ) Cough
( ) Distortion of spine	( ) Learning Disorder	( ) Genetic Disorder	
( ) Colic	( ) Headache	( ) Scoliosis	
( ) Ear Infections	( ) Autism	( ) Wellness	

( ) Other: _____

PARENT'S INFORMATION

Parent's First Name, M.I., and Last Name:_____

Street Address (include APT #): _____

City, State, and Zip: _____

Parent's Email Address: _____ Parent's Cell Phone:_____

Relationship to child: _____ Date of Birth: _____ Age: _____

Parent's Signature (I request services): _____

Why is it important to have your child checked for an atlas subluxation?

Studies have revealed that our first subluxation commonly occurs at BIRTH! Those of you who have seen the birth process know that it is a rough job coming through the birth canal. This is when the atlas first becomes misaligned (subluxated). This misalignment can sometimes lead to crib death, colic, constipation, ear infections, cough, ADD, ADHD, curvature of the spine (scoliosis), and other childhood health problems. Research shows that if a child was delivered non-vaginally (C-Section), the lack of "normal" compressional forces can compromise the lungs and brain. This "normal process" of birth normalizes pressure in the chest cavity and intracranial pressure in the infants head to allow for normal and optimal brain to body communication and funcation.

CHILD'S NAME: _____

PEDIATRIC HISTORY (*PLEASE PRINT CLEARLY)*

The following questions are designed to help the doctor provide a detailed evaluation of your child

HAS YOUR CHILD EVER HAD PEDIATRIC CHIROPRACTIC CARE BEFORE? Yes No Who: _____

NUTRITION

Yes No

____ ____ Is your child being breast fed? If no, how long was he/she breast fed? _____

____ ____ If still breast-feeding, how much cow's milk does the mother consume each day: _____

____ ____ Is your child formula fed? What formula or other milk source?_____

____ ____ Is your child eating solid food? What foods are in the diet? _____

____ ____ Does your child have feeding difficulties? _____

____ ____ Does your child have digestive disturbances? _____

____ ____ Does your child have food allergies? _____

____ ____ Does your child have persistent or intermittent skin rashes? _____

____ ____ Is your child receiving any vitamin supplements? _____

TRAUMA

Yes No

____ ____ Was your birth process smooth and natural?

____ ____ Did they use "force" to deliver?

____ ____ Was your child's birth non-medicated (for infant and adult)?

____ ____ Has your child had any recent falls or trauma?_____

____ ____ Has your child ever fallen down stairs, out of a high chair, rolled of a bed, or fallen from any height?

_____ _____ Has your child ever been in a motor vehicle accident or near-miss?

_____ _____ Has your child ever had a fracture or joint dislocation?

_____ _____ Has your child had any other trauma or injuries? _____

_____ _____ Does your child ever bang his/her head repeatedly against a wall, bed, or other object? _____

Parent's Signature: _____