HIGHPOINT HEALTH CENTER

Dr. Harry Schick DC, DAAIM, ABAAHP
317 Cleveland Ave
Highland Park, NJ 08904
732 249 9800

Dear Parent,

The more information I have initially, the better I will be able to work with you and help your child achieve the goals you have in mind for them.

Please take your time to answer all questions to the best of your ability.

Date: ______________________ Email Address:____

Patient's Name: ____

Name of Parent/ Guardian:____

Address: ____

City: _____________________________ State: ________________________ Zip: __________________

Telephone #: _________________________________ Cell #:_______________________________

Social Security #: ________________________________

Birth Date: ____________________________________ Gender: ☐ Male ☐ Female

How did you hear about our office ?

____

____

HIGHPOINT HEALTH CENTER

Dr. Harry Schick DC, DAAIM, ABAAHP
317 Cleveland Ave
Highland Park, NJ 08904
732 249 9800

List medical doctors or learning specialists you have seen in the past:

1) Name: ______________________________________ City: ___________________________

   Date of Last Visit:______________ Purpose of Visit: ____________________________________

2) Name: _______________________________________ City: _____________________________

   Date of Last Visit: ______________ Purpose of Visit: ____________________________________

3) Name: _______________________________________ City: __________________________

   Date of Last Visit: ______________ Purpose of Visit: ____________________________________

List Chiropractors that you have seen before:

Name & Approx. Date: ____

Name & Approx. Date: ____

List all current medications (In space below):

List child's developmental disorder or learning disability (for example, reading problem, balance, attention span, excessive activity, etc.), when did you first notice the problem, if it was diagnosed formally and whether you see the problem getting better or worse as time goes on.

Child's developmental disorder / learning disability	**When did you first notice the problem?**	**Was it diagnosed formally?**	**Is the problem getting better or worse?**	**Additional comments/ details if necessary**

HIGHPOINT HEALTH CENTER

Dr. Harry Schick DC, DAAIM, ABAAHP
317 Cleveland Ave
Highland Park, NJ 08904
732 249 9800

Specific goals, you as a parent would like to see:

Improve: ____

____

Behaviors you do not want to see anymore:

____

____

Have any family members been diagnosed with ADHD,ADD, Dyslexia, or any Autism Spectrum Disorders? Please list family member and diagnosis:

1. ____

2. ____

3. ____

Have any family members been diagnosed with an Autoimmune Disease, such as Hashimoto's Rheumatoid Arthritis, Lupus, Multiple Sclerosis, Grave's, or other ? Please list family member and diagnosis:

1. ____

2. ____

3. ____

HIGHPOINT HEALTH CENTER

Dr. Harry Schick DC, DAAIM, ABAAHP
317 Cleveland Ave
Highland Park, NJ 08904
732 249 9800

Current Diet

What is your child eating now? Look over the past 3 days and include as many foods as you can remember:

Usual breakfast:____

____

Usual Lunch: ____

____

Usual Dinner: ____

____

Favorite Snacks:

____

____

Foods or Food Groups your child refuses to eat:

____

____

Circle the drinks your child likes to drink:

Milk Soda Fruit Juice Sports Drink

HIGHPOINT HEALTH CENTER

Dr. Harry Schick DC, DAAIM, ABAAHP
317 Cleveland Ave
Highland Park, NJ 08904
732 249 9800

List other dietary patterns that may be important:

Digestive System:

How many bowel movements does your child have in a usual day ? __________

Does your child move their bowels every day? __________

Does your child tend to have dark circles under their eyes? __________

Does your child have gas and bloating ? __________

Circle any weather conditions where you noticed your child's behavior worsen:

Damp Hot Misty Moldy

Does your child wake up at night laughing or giggling? ___________

Does your child have a hard time falling asleep at night? ___________

Does your child have nightmares? ___________

Does your child sleep through the night? ___________

If not, does he/ she fall back to sleep easily? ____________

Mother's Health During Pregnancy:

Was Mom overweight ? ___________

Was Mom sick ? (If so, name illness) _____________________

How many previous child births did mother have ? _________

How many miscarriages ? _________

Did Mom refuse fertility drug/ treatment ? _________

Dr. Harry Schick DC, DAAIM, ABAAHP
317 Cleveland Ave
Highland Park, NJ 08904
732 249 9800

Health of child's siblings?____

____

Did Mother stress during pregnancy? (circle if appropriate)

Divorce	Accident	Fractures
Emotional Trauma	Death in Family	Loss of Job

If emotional trauma, please specify: ____

Mom's exposure to toxins: (mold, presticide, etc.) ____

____

Known infections Mom had during pregnancy: (circle if appropraite)

Virus Bacteria Yeast

Circle those things Mom did during pregnancy: (circle if appropriate)

Smoke Alcohol Caffeine Recreational Drugs

Medications Mom was on during pregnancy: ____

____

Birthing Process:

What type of delivery? ____

Any birth trauma ? ____

Was delivery included ? _______________ Epidural ? ____________ APGARScore ___________

Problems directly after birth: ____

HIGHPOINT HEALTH CENTER

Dr. Harry Schick DC, DAAIM, ABAAHP
317 Cleveland Ave
Highland Park, NJ 08904
732 249 9800

Infant Toxic Exposure :

Mold in house? ___________ Pesticide ?_____________ Other?_____________

Motor Development: Do the best with whatever you can remember

Child age when:

First held head up? ________ Rolled over? _________ Set up?_________

Crawled ? _______ Walked? ________ Potty trained?_________

Stopped wetting bed? ________ First words (Mama, Dada)? _________ Spoke 2 or 3 ? _________

Did child exhibit any unusual or “cute” crawling behavior ? _____________________________________

____

Has child lost language ? If yes, at what age and how far did they regress?_________________________

____

How many words was child using in a sentence before the regression?____________________________

Has the child lost eye contact? If so, when? ____

HIGHPOINT HEALTH CENTER

Dr. Harry Schick DC, DAAIM, ABAAHP
317 Cleveland Ave
Highland Park, NJ 08904
732 249 9800

Early Nurtrition :

Was child breast fed? _______ If yes, until what age? _______

If not breast fed, what type of formula was used? (soy, dairy, etc.) ______________________________

____

Age child started bottle feeding? ________ Age began milk? ________

Age began grains?_______

Vaccine Response :

Seizures? (If so, how long did they last?) ____

Bowel Symptoms? ____

Swelling at injection site?______________________________ Rash?____________________________

Other?____

Childhood Infection:

Name all infections and age on onset, first two years of life:

____ ____ Age: _________

____ ____ Age: _________

____ ____ Age: _________

____ ____ Age: _________

Is child currently on antibiotics? _________

Age child first used antibiotics? __________

HIGHPOINT HEALTH CENTER

Dr. Harry Schick DC, DAAIM, ABAAHP
317 Cleveland Ave
Highland Park, NJ 08904
732 249 9800

Surgeries:

List all surgeries, dates, reason:

____

Write below any additional information you think might be helpful: