



Pediatric History Form

(Please print, all information is confidential)

Dear New Patient:

It is our pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient's Name: _____ Referred by: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Other Ph: _____ E-mail: _____

Sex: M F DOB: _____ Age: _____ Weight: _____ Height: _____

Names of Parents / Guardians: _____

Do you have insurance? Y or N (If yes, please give the front desk your card to copy) _____

Purpose for Contacting Us? _____

Other doctors seen for this condition: ___ Y ___ N, Doctor's names and prior treatments: _____

Other health problems? _____

Check any of the following conditions your child has suffered from during the past six months:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Recurring Fevers |
| <input type="checkbox"/> Asthma / Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD | <input type="checkbox"/> Temper Tantrums |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Growing / Back Pains | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Chronic Colds | |

Family History: _____

Previous Chiropractor: _____

Date of last visit: _____ / _____ / _____ Reason: _____

Name of Pediatrician: _____

Date of last visit: _____ / _____ / _____ Reason: _____

Are you satisfied with the care your child has received there? _____ Y _____ N

Number of doses of Antibiotics your child has taken:

During the past six months: _____, Total during his/her lifetime: _____

Number of doses of other Prescription Drugs your child has taken:

During the past six months: _____, Total during his/her lifetime: _____

Vaccination history _____

Prenatal History:

Name of obstetrician / midwife: _____

Complications during pregnancy? _____ Y _____ N, List: _____

THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working toward the same objective.

Chiropractic had only one goal. It is important for each patient to understand both the objective and the method that will be used to attain it. This will prevent confusion or disappoint.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal, physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxations: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of the health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression to the body's innate wisdom. Our only method is the specific adjustment of vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

In case of emergency, notify _____ Phone # _____
_____ have read and fully understand the above statements. All questions
(Print Name)

regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I

therefore accept chiropractic care on that basis. _____
(Signature) (Date)

COMPLETE IF THE PATIENT IS A MINOR CHILD: Child's name: _____
_____, being the parent or legal guardian of the aforementioned child have read and
(Parent/Guardian Print Name)

fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

(Parent's/Guardian's Signature) (Date)

Ultrasounds during pregnancy? _____ Y _____ N, Number: _____
 Medications during pregnancy / delivery? _____ Y _____ N, List: _____
 Cigarette / Alcohol use during pregnancy? _____ Y _____ N
 Location of birth: _____ Hospital _____ Birthing Center _____ Home _____
 Birth intervention: _____ Forceps _____ Vacuum extraction _____ C-Section, Emergency _____ or Planned _____?
 Complications during delivery? _____ Y _____ N, List: _____
 Genetic disorders or disabilities? _____ Y _____ N, List: _____
 Birth Weight: _____ Birth Length: _____ APGAR scores: _____ , _____

Feeding History:

Breast Fed: _____ Y _____ N, How Long? _____
 Formula Fed: _____ Y _____ N, How Long? _____
 Introduced to solids at: _____ months, cow's milk at _____ months
 Food / juice allergies or intolerances: _____ Y _____ N,
 List: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to?

_____ Respond to sound _____ Respond to visual stimuli _____ Hold head up
 _____ Sit up _____ Cross crawl _____ Stand alone
 _____ Walk alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child?
 _____ Y _____ N

Is or has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? _____ Y _____ N, List: _____

Has your child ever been involved in a car accident? _____ Y _____ N, List: _____

Other traumas not described above? _____ Y _____ N,

List: _____

Prior surgery: _____ Y _____ N,

List: _____

Menarche: _____ Y _____ N, Age: _____

Childhood Diseases

Chicken Pox Y/N, Age: _____ Mumps Y/N, Age: _____ Rubella Y/N, Age: _____
 Rubeola Y/N, Age: _____ Whooping Cough Y/N, Age: _____ Other Y/N, Age: _____

**WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
 YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.**

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctors to administer care to my son/daughter as they deem necessary. I do clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: _____ Witnessed: _____ Date: ____/____/____