PEDIATRIC HISTORY FORM

Dear New Patient,

It is a 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 Name: _____ S.S. #: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Home #: _____

Birth Date: ____/____/____ Sex: ☐ Male ☐ Female Weight: _____ Height: _____

Name(s) of Parents / Guardians: _____

Referred By: _____

Purpose for contacting us? _____

Other doctors seen for this condition: ☐ No ☐ Yes If yes, Doctors' names and prior treatments: _____

_____

Other health problems? _____

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

☐ Ear Infections	☐ Scoliosis	☐ Seizures	☐ Chronic Colds	☐ Headaches
☐ Asthma / Allergies	☐ Digestive Problems	☐ ADHD	☐ Recurring Fevers	☐ Growing / Back Pains
☐ Colic	☐ Bed Wetting	☐ Car Accident	☐ Temper Tantrums	☐ Other: _____

Family History: _____

Previous Chiropractic Care: ☐ No ☐ Yes Chiropractor name: _____

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

Name of pediatrician: _____

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

Are you satisfied with the care your child has received there? ☐ No ☐ Yes

Number of doses of antibiotics your child has taken:

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

Number of other prescription medications your child has taken:

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

Vaccination History: _____

Prenatal History

Name of Obstetrician / Midwife: _____

Complications during pregnancy? ☐ No ☐ Yes List: _____

Ultrasounds during pregnancy? ☐ No ☐ Yes Number: _____

Medications during pregnancy / delivery? ☐ No ☐ Yes List: _____

Cigarette / Alcohol use during pregnancy? ☐ No ☐ Yes

Location of birth: ☐ Hospital ☐ Birthing Center ☐ Home

Birth Intervention: ☐ Forceps ☐ Vacuum Extraction ☐ Caesarian Section: Emergency or Planned?

Complications during delivery? ☐ No ☐ Yes List: _____

Genetic disorders or disabilities? ☐ No ☐ Yes List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

Feeding History

Feeding type: ☐ Breast Fed ☐ Formula Fed How long: _____

Introduced to: solids at _____ months Cows milk at _____ months

Food / Juice allergies or intolerance: ☐ No ☐ Yes 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. At what age was your child able to:

Respond to sound: _____ Cross Crawl: _____

Respond to visual stimuli: _____ Stand alone: _____

Hold head up: _____ Walk alone: _____

Sit up: _____

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? ☐ No ☐ Yes

Is / has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ☐ No ☐ Yes List: _____

_____

Has your child ever been involved in a car accident? ☐ No ☐ Yes List: _____

Has your child ever been seen on an emergency basis? ☐ No ☐ Yes List: _____

Other traumas not described above? ☐ No ☐ Yes List: _____

Prior surgery? ☐ No ☐ Yes List: _____

Menarche? ☐ No ☐ Yes List: _____

Childhood Diseases

Chicken Pox: ☐ No ☐ Yes, Age: _____ Mumps: ☐ No ☐ Yes, Age: _____

Rubella: ☐ No ☐ Yes, Age: _____ Rubeola: ☐ No ☐ Yes, Age: _____

Whooping Cough: ☐ No ☐ Yes, Age: _____ Other: _____ Age: _____

AUTHORIZATION FOR CARE OF A MINOR

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

Signature of Parent / Guardian: _____ Date: _____

Printed Name: _____

If you have insurance coverage for chiropractic care, please provide the front desk with a copy of your card and any additional information needed to bill for your care.

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 to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health** is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation.** This occurs when one or more of the 24 vertebra in the spinal column become misaligned and / or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment.** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	Signature	Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____	_____
Signature	Date