Pediatric History Form **Date of appt_______________Time_________**

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.

Subluxations or spinal misalignments are a condition of the spine that Chiropractors are trained to detect. Research is now showing that dysfunction within the body can be the result of these subluxations. Often other symptoms are apparent for years before spinal pain is noticed. It is for this reason we ask a wide variety of questions regarding your health.

Patient Name_______________________________Nick Name_______________________

Birth Date _______________ Sex ☐ M ☐ F Weight__________ Height__________

Name of Parents / Guardians____

Address City State Zip ____

Home Phone_______________ Parent's Work Phone_______________ Cell Phone__________

Number and ages of siblings____

Email Address_______________________________May we send you office newsletters? ☐ Yes ☐ No

How did you hear about our office? ____

FAMILY HEALTH HISTORY

Previous Chiropractor: ___________________________ Date of last visit & Reason: __________

____

Name of Pediatrician: ___________________________ Date of last visit & Reason: __________

____

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

Number of antibiotics your child has taken: Past 6 months________ Total during his/her lifetime________

Circle all drugs you are taking including prescription and non-prescription drugs,

☐ Tylenol, Advil ☐ Allergy ☐ Asthma ☐ Anti-Depressants

☐ Cold tablets ☐ ADHD ☐ Painkillers

Other: ____.

Does your child take any Vitamins or Herbs? ☐ No ☐ Yes _________________________.

PRENATAL HISTORY

Location & type of Birth Attendant: ☐ Home ☐Birthing Center ☐ Hospital ☐ OBGYN ☐ ☐ Midwife

Complications during pregnancy: ☐ No ☐ Yes List: _____________________________

Ultrasounds during pregnancy: ☐ No ☐ Yes How Many: _____ Birth intervention: ☐ Forceps ☐ Vacuum

☐ Caesarian: Planned or Emergency Complications during delivery: ☐ No ☐ Yes __________

Medications during pregnancy / delivery: ☐ No ☐ Yes List: ______________________

Cigarette or Alcohol during pregnancy: ☐ No ☐ Yes Breast Fed: ☐ No ☐ Yes How long? __________

Birth weight________ Birth length________ Formula fed: ☐ No ☐ Yes How long? __________

APGAR scores________ Solids at ____ months Did he/she have teeth?______

Cow's milk at ________ months Food/juice allergies or intolerances ☐ No ☐ Yes

Anything else that needs to be noted:_______________________________________

GROWTH & DEVELOPMENT

Was the infant alert and responsive within 12 hours of delivery? ☐ No ☐ Yes

If No, please explain ____________________

At what age did the child: Respond to sound ________ Follow an object _______ Hold up head ________

Vocalize ________ Sit alone ________ Crawl ________ Walk ________

Do you consider your child's sleeping pattern normal? ☐ No ☐ Yes Number of hours sleeping per night: ______

Quality of sleep: Good Fair Poor

VACCINATION HISTORY

Any complications such as excessive crying, fevers, convulsions, loss of development? ____________________

CHILDHOOD DISEASES

Chicken Pox ☐ No ☐ Yes Age _______ Mumps ☐ No ☐ Yes Age _______ Rubella ☐ No ☐ Yes Age _______

Whooping cough ☐ No ☐ Yes Age _____ Other ____________________ ☐ No ☐ Yes Age _______

Has your child ever suffered from: (Check all that apply)

☐ Dizziness ☐ Backaches ☐ Heart trouble ☐ Chronic earaches ☐ Diabetes ☐ Shortness of breath ☐ Colds / Flu ☐ Hypertension ☐ Arthritis ☐ Headaches ☐ Asthma ☐ Allergies

☐ Fatigue ☐ Digestive ☐ Sinus ☐ Constipation ☐ Anemia ☐ Diarrhea ☐ Poor Appetite ☐ Hyperactivity ☐ Urinary problems ☐ Behavioral ☐ Bed Wetting ☐ Convulsions

☐ Loss of smell ☐ Muscle jerking ☐ Fainting ☐ Walking problems ☐ Broken bones ☐ Ruptures / Hernias ☐ Neck Problems ☐ Arm problems ☐ Leg problems ☐ Growing pains ☐ Joint Problems ☐ Blood disorders

☐ Stomach aches ☐ Irritability ☐ Sore throats ☐ Depression ☐ Loss of balance ☐ Bronchitis ☐ Poor coordination ☐ Muscle Cramps ☐ Acid Reflux ☐ ADD/ADHD ☐ Epilepsy

Which of the above conditions do you expect to be helped with chiropractic care?

____

CONSULTATION

Reason for seeking chiropractic care: ____________________

When did the problem begin? ____________________

Is this problem ☐ occasional ☐ frequent ☐ constant ☐ intermittent ☐ other ____________________

Does the problem radiate? ☐ No ☐ Yes If yes, where? ____________________

What makes it worse? ____________________

What makes it better? ____________________

Is the problem worse during a certain time of the day? ☐ No ☐ Yes If YES, when? ____________________

Does this interfere with the child's ☐sleep ☐eating ☐daily routine? Is this becoming worse? ☐ No ☐ Yes If yes, how? ________________________________ Other professionals seen for this condition? ____________

Results with treatment? ____

Other Health Problems ____

According to the National Safety Council, 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.). Is this the case with your child? ☐ No ☐ Yes

When was your child's most recent fall? ________________________________ What happened?

____

The vast majority of our patients have experienced dozens of falls or impacts (auto/work/sports/hobbies) that could either begin or exacerbate subluxations. Help us discover a few of your child's.

Which of the following sports have your child been involved in?

☐Football	☐ Soccer	☐Cheerleading	☐ Running
☐ Basketball	☐ Gymnastics	☐ Martial Arts	☐ Horseback riding

☐ Other: ____.

Has your child ever .... ☐ Fallen down the stairs ☐ Slipped/Fell on the ground (or ice) ☐ had a sports injury. Had a stress or strain while at school ☐ Broken a bone ☐ if so, which one? ____________________.

Has your child ever been involved in a car accident? ☐ No ☐ Yes, Was there impact? ☐ No ☐ Yes, Was there injuries ☐ No ☐ Yes? (Dates/any treatment) ________________________________

____

Has your child ever been seen on an emergency basis? ☐ No ☐ Yes (please list all) ____________

____

Other traumas not described above? ☐ No ☐ Yes ________________________________

Prior surgery: ☐ No ☐ Yes Type and Date: ____________________ Menses: ☐ No ☐ Yes Age: ________

REGARDING PAYMENT AND AUTHORIZATION TO TREAT A MINOR:

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making a collection from the insurance company and that any amount authorized to be pain directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. I also understand that if I terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary, this includes radiographic examination at the doctor's discression. It is understood and agreed the amount paid to the Doctor for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The parent also agrees that he/she is responsible for all bills incurred at this office for their child and agrees to pay minimal charges for all services and products rendered. To waive the right of notice or exemption within the state of Alabama or any other state in regard to personal property , allows one and one half (1½%) per month to any balance owed. In the event of default to also pay reasonable collection charges, attorney fees and court cost.

As of this date, I have the legal right to select and authorize health care services for the minor child. Under the terms and conditions of my divorce separation or other legal authorization, the consent of a spouse/ former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Child's Name ________________________ Signature of parent/guardian ________________________

Date of signature ____