Pediatric History Form

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. Many types of stressors (physical, mental, and chemical) can interfere with your child's growing brains, spine and nervous system. 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.

Child's Name: ____ Birth Date: ___/___/____

Male/ Female (Circle one) Weight: _____lbs. Height_____ft_____in. Phone #______________________

Address:____City:_____________________________

State:______________ Zip:_______________ Parent/ Guardian:____

Referred by:_______________________________

Reason for pursuing care: ☐ Maintenance ☐ Improved Health ☐ Problem:______________________

Other Doctors seen for this condition? Y/ N Doctor's names and prior treatment:

____

____

List any other health problems: ____

Family history: ____

Check any of the following conditions that currently apply:

___ Ear infections	___ Scoliosis	___ Chronic colds	___ Headaches
___ Allergies	___ Digestive problems	___ ADHD/ADD	___ Recurring Fevers
___ Colic	___ Growing/ back pain	___ Bed wetting	___ Temper tantrums
___ Seizures	___ Asthma	___ Car accident: When?____________	

Other: ___________________

Previous Chiropractic Care? Y/ N Last Visit: __/__/__
Name of Chiropractor: _______________________________________
Name of Pediatrician: ____ Last Visit: __/__/__

# of Doses of antibiotics your child has taken: Past 6 months________ Total lifetime ________

Present prescription drugs/ dosage? ____

Past prescription drugs/ dosage? ____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.) ____

Pediatric History Form Continued

Name of Obstetrician/ Midwife: ____

Complications during pregnancy/ delivery? Y/N Explain:______________________

Ultrasounds during pregnancy? Y/N How many?________

Medications taken during pregnancy/ delivery? Y/N List:_____________________

Cigarette/ Alcohol use during pregnancy? Y/N

Location of birth (circle one): Hospital Birth Center Home

Birth Intervention (circle one): Forceps Vacuum Extraction Caesarian Section

If Caesarian Section, was it: _____Emergency or _____ Planned (check one)

Genetic disorders/ disabilities? Y/N List: _______________________________

Birth Weight: _________________ Birth Length: _______________ APGAR Scores: ______-______

Feeding History

Breast Fed: Y/N How long? __________ Formula Fed: Y/N How long? ________ Type:________

Introduced to: Solid Foods @__________months Cow's milk @__________months

Food/ Juice allergies or intolerances: Y/N List: ______________________________

Developmental History

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 stimuli __________ Cross Crawl __________ Stand alone

_________ Respond to visual stimuli __________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)

Did your child have a fall similar to what was described above? Y/N
Explain:____

Has your child been involved in any sports? Y/N List: ______________________

____

Has your child been seen by a physician on an emergency basis? Y/N Explain:___________

____

Other traumas not described above? ____________________________________

Lifestyle

Does your child: ☐ Eat health foods (organic products, etc.) ☐ Drink water

☐ Take vitamins Type: ______________________________ ☐ Take probiotics

Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Hobbies/interests: ____

____

Is there anything else you would like us to know about your child? ____________________

I understand that I am directly and fully responsible to Steadfast Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ *Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.*

____ ____________________

Parent or Legal Guardian's Signature *Date*

Doctor Signature ____________________ *Date*____________

Please provide a list of anyone you give us permission to speak to about your Child's Health, Financials or both:

Please circle one of the following:

Name: ________________ Relationship to child: ____________________ Health Financials Both

Name: ________________ Relationship to child: ____________________ Health Financials Both