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: ____________ Home Phone: ______________________

Birth Date: ______/________/ ______ Work Phone: ______________ ______________

Sex: ________ Weight: ________ Height: ________ Referred By: ______________________

Names of Parents / Guardians: ______________________________

Purpose For Contacting Us? ______________________________

Other Doctors Seen for this Condition: ______ N ______ Y , 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 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 ? ______ N ______ Y

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 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 ? ______ N ______ Y , List: ______________________

Ultrasounds During Pregnancy ? ______ N ______ Y, Number: ______

Medications During Pregnancy / Delivery ? ______ N ______ Y , List: ______________________

Cigarette / Alcohol Use During Pregnancy: ______ N ______ Y

Location of Birth: ______ Hospital ______ Birthing Center ______ Home

Birth Intervention: _______ Forceps________ Vacuum Extraction

_______ Caesarian Section, Emergency or Planned?

Complications During Delivery ? _______ N_______ Y, List: ____________

Genetic Disorders or Disabilities: _______ N_______ Y, List: ____________

Birth Weight: _______ Birth Length: _______ APGAR Scores: _______

Feeding History:

Breast Fed: _________ N _______ Y, How Long: __________

Formula Fed: _______ N _______ Y, How Long: __________ Type: ______

Introduced to Solids at: ________ Months, Cows' Milk at ________ Months

Food / Juice Allergies or Intolerances: _______ N _______ Y, 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? _______ N ______ Y

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.) ? _______ N________ Y, List: ______________________________

Has Your Child Ever Been Involved in a Car Accident? _______ N _______ Y, List: ______________________

Has Your Child Been Seen on an Emergency Basis? _______ N _______ Y, List: ______________________

Other Traumas Not Described Above? _______ N _______ Y, List: ______________________

Prior Surgery: _______ N _______ Y, List: ______________________________

Menarche: _______ N _______ Y, Age: ________

Childhood Diseases:

Chicken Pox	N / Y, Age_______	Mumps	N / Y, Age _______
Rubella	N / Y, Age_______	Whooping Cough	N / Y, Age _______
Measles	N / Y, Age_______	Other	N / Y, Age _______

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

INFORMED CONSENT:

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment Objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Restoration Chiropractic have been explained to me to my satisfaction, and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care. I also consent to having my x-rays used anonymously for patient education and teaching needs.

______________________________ ____________ ☐

Patient or Authorized Person's Signature   Date   Witness Initials

REGARDING: X-rays/Imaging studies:

<u>FEMALES ONLY</u> → Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on ____ - ____ - ____

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I AM NOT PREGNANT.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

______________________________ ____________ ☐

Patient or Authorized Person's Signature   Date   Witness Initials