

TOUCH OF LIFE CHIROPRACTIC

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.

General Information:

Patient Name: _____ S.S.#: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Work Phone: _____ Birth

Date: ____/____/____ Sex: ____ Weight: _____ Height: _____

Names of Parents/Guardians: _____

Referred By: _____

Purpose for contacting us? _____

Other Doctors Seen for this Condition? N ____ Y ____

If Yes, Doctors' Names & Prior Treatments _____

Other Health Concerns? _____

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

- | | | | | |
|--|---|---|---|--------------------------------------|
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic Cold | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHS/ADD | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Growing/Back Pain | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Accident Car/Falls | <input type="checkbox"/> Temper Tantrum | <input type="checkbox"/> Other _____ |

Family History: _____

Previous Chiropractor: _____ Last Visit: _____

Reason: _____

Pediatrician: _____ Last Visit: _____

Reason: _____

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

Number doses of antibiotics your child has taken:

During past 6 months: _____ Total lifetime _____

Number of doses of other prescription medications your child has taken:

During the past 6 months: _____ Total lifetime _____

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: City/State: _____

Hospital? _____ Home Birthing Center _____ Home _____

Birth Intervention: N____ Y____ Forceps _____ Vacuum Extraction _____

Cesarean Section _____ Emergency or Planned?

Genetic disorders or disabilities N____ Y____ List: _____

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

Feeding History:

Breast Feed: N____ Y____ How Long? _____

Formula Fed: N____ Y____ How Long? _____ Formula Type: _____

Introduced to Solids: _____ Months, Cows Milk? _____ Months/Years

Food/Juice allergies or intolerance's that you know of: 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 prevention and early detection of vertebral subluxation (spinal nerve interference). 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? N____ Y____

Is/has your child been involved in any high impact or contact type sports (i.e. Soccer, Football, Hockey, Gymnastics, Baseball, Cheerleading, Martial Arts, Wrestling, 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: _____

For Female Menarche N_____ Y_____ Age: _____

Childhood Diseases:

Chicken Pox N/Y Age _____

Mumps N/Y Age _____

Rubella: N/Y Age _____

Whooping Cough N/Y Age _____

Rubeola: N/Y Age _____

Other N/Y Age _____ Kind _____

We are here to serve you and encourage you to ask questions.

Your participation is vital and will help your results.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize the 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 the office.

Name of Insurance Company: _____

Policy#: _____

Signed: _____ Witnessed: _____

Date: _____