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:______________________________ SS#: ______________________________

Address: ______________________________ City/State/Zip:______________________

Birthdate: ____________ Home Phone: ________________ Work Phone: ____________________

Sex: _____ Height: ________ Weight: _______ Referred By: ____________________________

Names of Parents/Guardians: ____

Purpose for Contacting Us? ____

Other Doctors seen for this condition? ☐ Yes ☐ No
Doctor's Names and Prior Treatments:____

____

Other Health Problems? ____
Check any of the following conditions your child has suffered from during the past six (6) months:

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

Family History: ____

Previous Chiropractor: __________________________ Date of Last Visit: __________________

Reason for visit: ____

Pediatrician: __________________________________ Date of Last Visit: __________________

Reason for Visit: ____

List any Medications Your Child has Taken: ____

Vaccination History: ____

Prenatal History:

Name of Obstetrician/Midwife: __________________________ Location of Birth: ______________

Complications During Pregnancy? ☐ Yes ☐ No List: _____________________________________

List Medications During Pregnancy/Delivery: ____

Smoking/Alcohol use during Pregnancy? ☐ Yes ☐ No

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 effect 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 vertebrae in the spinal column become misaligned and/or do not move properly. This causes an 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, alternatives of chiropractic care have bee 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 advises an x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ____________________________

________________________________	________________________________	_______________
Print Name	Signature	Date