CHILDREN'S CHIROPRACTIC HISTORY

Today's Date:_____

Child's Name:_____ Email Address:_____

Mother's Name:_____ Father's Name:_____

Address:_____ City:_____ State_____ Zip_____

Home Phone: (___)_____ Father's Cell Phone:_____Mother's Cell Phone:_____

Insurance Co:_____ Ins. Address:_____

Insured's Name:_____ Insured's Date of Birth:_____

Insured's Employer:_____ Insured's SS#:_____

Child's Birthdate:_____ Age:_____ Birth Weight:_____ Current Weight:_____

Sex:_____ # of Siblings:_____ Birth Length:_____ Current Height:_____

Purpose for contacting our office:_____

Who referred you to our office:_____

Prenatal History:
Problems during pregnancy:_____

Medications during pregnancy:_____ OB/Gyn. Name:_____

OB/Gyn. Phone #:_____

Labor/Birth History:
Problems During Labor/Delivery:_____

Type of Birth: Vaginal:_____ Forceps:_____ Vacuum Extraction:_____ Breech_____

Cesarean: Emergency:_____ Planned:_____ Reason:_____

Epidural:_____ Medications during labor:_____

Place of Birth: Home_____ Birthing Center:_____ Hospital:_____

Apgar Scores: _____ _____ Was there presence of:_____ Jaundice (Yellow)

_____ Cyanosis (Blue)
Congenital Anomalies/Defects:_____

Infant Feeding History:
Breastfed:_____ How long?_____ Formula:_____ How long?_____

Introduced to solids at what age:_____ First solid food(s):_____

Introduced to cow's milk at what age:_____ Any known food allergies?_____

Medical History:
Pediatrician's Name:_____ Pediatrician's Phone #:_____

Date of last visit:_____ Are you satisfied with care there?_____

# of antibiotics prescribed: During the past 6 months?_____ Reason:_____

Total during his/her lifetime?_____ Reasons:_____

Number & explanation of other prescriptions:_____

_____

Has your child had any surgeries or illnesses?_____

Vaccination History:_____ Has he/she had any known side effects or

allergic reactions from their vaccines?_____

Does your child have learning disabilities/ autism/ or ADHD?_____

Has your child been treated on an emergency basis?_____

Describe:_____

Has your child ever been involved in a car accident?_____ If yes, when?_____

According to the National Safety Council, approximately 50% of children fall head first from a high place their first year of life! Did this happen to your child? Y N If yes, how old was he/she?_____

Where was the fall(s) from?_____

Developmental History:
During the following times, a child's spine is most vulnerable and should routinely be checked by a Doctor of Chiropractic for Prevention and Early Detection of the Subluxation Complex.
At what Age was your child able to:

_____Respond to Sound
_____Cross Crawl
_____Respond to Visual Stimuli
_____Stand Up
_____Hold Head Up
_____Walk Alone
_____Sit Up

HAS YOUR CHILD EVER SUFFERED FROM:

_____Allergies _____Digestive Problems _____Eye Problems
_____Hyperactivity
_____Asthma _____Ear Infections/fluid _____Respiratory Infections
_____Scoliosis
_____Bedwetting ____Poor Immune response _____Headaches
_____Dizziness
_____Colic _____Hearing Problems _____Tonsilitis
_____Growing Pain

I hereby authorize this clinic and its Doctor(s) to administer care as they so deem necessary to My Son / Daughter / Ward.

Signed:_____ Date:_____

Signature on file and authorization to release medical information:
I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO THE DOCTOR FOR SERVICES PROVIDED. I FURTHER AUTHORIZE THE DOCTOR TO RELEASE ANY INFORMATION REQUIRED TO PROCESS INSURANCE CLAIMS.

Signed:_____ Date:_____