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
☐ Respond to Visual Stimuli
☐ Hold Head Up
☐ Sit Up
☐ Cross Crawl
☐ Stand Up
☐ Walk Alone

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: _____