New Patient
Pediatric
Registration & History

Our Mission

To assist our patients in reaching their optimum health potential through Education, Truth, and Chiropractic care. To love, serve, give and teach.

PEDIATRIC HISTORY/CONSENT 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 help you and your family to 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, Doctor's 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:______List:_____________________________

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 Pregancy?_______N______Y, List:____
Cigarette/Alcohol Use During Pregnancy:_______N_______Y
Location of Birth:______Hospital______Birthing Center______Home
Birth Intervention:______Forceps______Vacuum Extraction______Ceasarian Section, Emergency or Planned?
Complication 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:_______________________________________
Introduction 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?____Y____N

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 ever 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	Y / N	Age:______	Mumps	Y / N	Age:______
Rubella	Y / N	Age:______	Whooping Cough	Y / N	Age:______
Roseola	Y / N	Age:______	Other	Y / N	Age:______

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

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this 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 this office.

Signed:_____________________________Witnesses:______________________________Date:_______________

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