CROSSROADS
CHIROPRACTIC

# PEDIATRIC HISTORY FORM

**Dear New Patient,**

It is our 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's Full Name:_____What do you prefer to be called?_____

Legal Address:_____ City:_____

State:_____Zip:_____ Home Phone:_____

Mailing Address: (if different from Legal Address) _____

City:_____State:_____Zip:_____

Birth Date:_____/_____/_____ Sex:_____ Weight:_____ Height:_____

Names of Parents / Guardians:_____

Parents/Guardian Contact Information:_____

**Purpose For Contacting Us?** _____

Referred by?_____

Doctors' Names and Prior Treatments:_____

_____

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 ___ADHD ___Recurring fevers ___Colic ___Growing/Back Pain
___Bed wetting ___Car Accident ___Digestive Problems ___Temper Tantrums ___Other:_____

Other Health Problems?_____

Previous Chiropractor:_____ Date of last visit:_____ Reason:_____

Name of Pediatrician:_____ Date of last visit:_____ Reason:_____

Are you satisfied with the care which your child has received there? _____Yes ____No

Number of Doses of Antibiotics Your Child has Taken:
During the past six months:_____ Total During his / her lifetime:_____

Number of Doses of Other Prescription Medications Your Child has Taken:
During the past six months:_____ Total During his / her lifetime:_____
Please list:_____

Vaccination History:

_____

**PRENATAL HISTORY**

Name of Obstetrician / Midwife:_____

Complications during pregnancy? ____No ____Yes If Yes, please list:_____

Ultrasounds during pregnancy? _____No _____Yes; Number:_____

Medications during pregnancy / delivery? ____No _____Yes; List:_____

Cigarette / Alcohol use during pregnancy? _____No ____Yes

Location of Birth: _____Hospital _____Birthing Center _____Home _____Other:_____

Birth Intervention: _____Forceps____Vacuum Extraction _____Caesarian Section:(please circle) emergency or planned

Complications during delivery? _____No _____Yes List:_____

Genetic Disorders or Disabilities: _____No _____Yes List:_____

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

Was delivery within 2 weeks of due date? _____No _____Yes # of days premature / late:_____

**FEEDING HISTORY**

Breast fed: _____No _____Yes How long?_____

Formula fed: _____No _____Yes How long?_____ Type:_____

Introduced to solids at: _____months; Cow's Milk at _____months

Food / Juice Allergies or Intolerances: _____No _____Yes

List:_____

**DEVELOPMENTAL HISTORY**

During the following times your child 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 1st year of life (i.e. a bed, changing table, stairs, etc.) Was this the case with your child?
___No ___Yes

Is / Has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.) _____No _____Yes List:_____

Has your child ever been involved in a car accident? _____No ____Yes List:_____

Has your child been seen on an emergency basis? ____No ____Yes List:_____

Other traumas not described above? ____No ____Yes List:_____

Prior surgery: ____No ____Yes List:_____

Menarche: _____No _____Yes Age:_____

**Childhood Diseases (*please circle)*:**

| | | | |
|---|---|---|---|
| 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_____ |

Family Medical History:_____

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

I hereby authorize the doctor to provide any and all forms of evaluation, x-rays (which are not usually necessary in pediatric care and will be discussed) and care that may be indicated in connection with the patient above, and further authorize and consent that the doctor chooses and employs such assistance as she sees fit. I also understand that prior to care, full explanation of the procedures involved will be given. I agree to pay all services rendered in this office.

Signature:_____ Date:____/____/____ Relationship to patient:_____

It is important that our patients and we have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called, we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe that the greatest doctor is the one already inside of each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. If eligible, I accept chiropractic care on this basis. I hereby attest to the fact that the above information is true and accurate.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature Date Completed

_____ _____ - _____ - _____
Reviewed by: Doctor's Signature Date Form Reviewed

**AUTHORIZATION FOR CARE OF MINOR**

I hereby authorize this office and its doctors to administer care for 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.

Signature:_____ Date:_____/_____/_____

Relationship to patient:_____

**Thank you!**