

Welcome to Family First Chiropractic

Pediatric History Form

Today's Date ___/___/___

Patient's Name: _____ What patient prefers to be called? _____

Parents/Guardian's Names: _____

Home Phone: _____

Mailing (Street) Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian's email address (for patient newsletter): _____

Patient's Birth Date: ___/___/___ Age: _____ Sex: Male Female

Social Security #: _____

How did you learn about our office? _____

Has patient had previous Chiropractic Care? No Yes (& approximate last visit date _____)

Please Check reason(s) for pursuing Chiropractic care for your child:

- She/He is continuing ongoing care from another Chiropractor
- I recently had my spine checked and I see the value in getting my child checked.
- I'm concerned about his/her health and I'm looking for answers.
- She/He has a specific condition that concerns me.

Explain condition or symptom: _____

- I want to improve my child's immune function.
- I have no idea why we are here. Please take the time to explain to me what you do for children.

In order for us to better understand your child's current level of health, please check any of the following Body Signals which your child has or has had previously:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> PDD/Autism |
| <input type="checkbox"/> Postural Imbalance | <input type="checkbox"/> Seizures | <input type="checkbox"/> Growing/Back Pains | <input type="checkbox"/> Car Accident |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Colic | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Ear Infection |
| <input type="checkbox"/> Other: _____ | | | |

(Continue Form on Other Side)

Please list Prescription or Over the Counter Medications now taken: _____

Known Allergies: _____

Number of doses of Antibiotics your child has taken:

During the past 6 months: _____ Total during his/her lifetime: _____

List Reasons: _____

Number of doses of other Prescription Medications taken:

During the past 6 months: _____ Total during his/her lifetime: _____

List Medications: _____

Prenatal History:

Adopted? No Yes

Complications during pregnancy? No Yes (& list: _____)

Ultrasounds during pregnancy? No Yes (& how many: _____)

Medications/drugs/caffeine during pregnancy? No Yes (& list: _____)

Cigarette/Alcohol use during pregnancy? No Yes

Location of Birth: Hospital Birthing Center Home

Birth Intervention (Please check any that apply):

Mother Induced Mother Medicated (Pitocin, etc.) Caesarian Section

Forceps Vacuum Extracted

Baby given medication after delivery: _____

Complications during delivery? No Yes (& list: _____)

Genetic Disorders or Disabilities? No Yes (& list: _____)

Breast Fed? No Yes (& how long?: _____)

Formula Fed? No Yes (& how long?: _____)

Food Allergies or Intolerances? No Yes (& list: _____)

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 each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept for your child, if eligible, Chiropractic care on this basis.

Parent/Guardian Signature: _____

Date: ___/___/___