RIVERTOWN FAMILY CHIROPRACTIC

PEDIATRIC HISTORY FORM

PATIENT INFORMATION

Child's Name _____ Parent(s)/Guardian(s) Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Is it okay to contact you at work? ☐ Yes ☐ No

E-mail _____ Birthdate _____ Age _____ Gender Male ☐ Female ☐

Have your or your child ever had chiropractic care before? ☐ Yes ☐ No

If yes, please tell us the doctor's name _____

Were you pleased with your care? ☐ Yes ☐ No

How did you find out about our office? _____

Is this appointment related to an auto accident? ☐ Yes ☐ No

If this injury is related to an auto accident, please fill out the Auto Accident Questionnaire.

Is your child receiving care from other health professionals? ☐ Yes ☐ No

If yes, please name them and their specialty _____

Who is your family's primary care physician? _____

Please list any drugs or medications your child is taking _____

Please list any vitamins/herbs/homeopathics/other your child is taking _____

Please list any allergies your child has _____

CURRENT HEALTH

What health condition brings your child to our office? _____

When did the symptoms first begin? _____

How did the problem start? ☐ Suddenly ☐ Gradually ☐ Post-Injury

Is this condition ☐ Getting Worse ☐ Improving ☐ Intermittent ☐ Constant ☐ Not Sure

What makes the problem better? _____

What makes the problem worse? _____

Has your child ever had a similar condition? ☐ Yes ☐ No

Please explain _____

Has your child been treated for this problem before? ☐ Yes ☐ No

Please explain _____

Does your child eat well? ☐ Yes ☐ No Does your child have regular bowel/bladder movements? ☐ Yes ☐ No

Has your child ever been checked for vertebral subluxations? ☐ Yes ☐ No ☐ Don't Know

HEALTH HISTORY

Child's birth was ☐ At home ☐ At a birthing center ☐ At a hospital

My obstetrician/midwife/family physician was _____

Child's birth was ☐ Natural vaginal (no medications/interventions)

☐ Vaginal with interventions

☐ Induction ☐ Pain medication ☐ Epidural ☐ Episiotomy ☐ Vacuum extraction ☐ Forceps

☐ Other _____

☐ C-section

☐ Scheduled ☐ Emergency

Please list reasons for any interventions/complications _____

_____

Child's birth weight _____ Child's birth height _____ Current weight _____ Current height _____

APGAR Score at birth _____ APGAR Score after 5 minutes _____

GROWTH & DEVELOPMENT

Was your child alert and responsive within 12 hours of delivery? ☐ Yes ☐ No

If no, please explain _____

At what age did the child:

Respond to sound _____ Follow an object _____ Hold head up _____ Vocalize _____

Sit alone _____ Teethe _____ Crawl _____ Walk _____

Patient/Hospitalization/Surgical history (please list below all surgeries and hospitalizations, including the year)

_____

_____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year

_____

_____

Is/was your child breastfed? ☐ Yes ☐ No If yes, how long? _____

Formula introduced at age _____ What type? _____

Introduction of cow's milk at age _____ Began solid foods at age _____

Please list any foods/juice intolerance _____

Did mother smoke during pregnancy? ☐ Yes ☐ No

Did mother drink alcohol during pregnancy? ☐ Yes ☐ No

Any illness of mother during pregnancy? ☐ Yes ☐ No

If yes, please explain including treatment/medications/supplements _____

_____

List any drugs/medications (including over the counter) taken during pregnancy _____

_____

List any supplements taken during pregnancy _____

Any exposures to ultrasound? ☐ Yes ☐ No If so, how many and what was the medical reason? _____

_____

Any pets at home? ☐ Yes ☐ No Any smokers at home? ☐ Yes ☐ No

GROWTH & DEVELOPMENT CONTINUED...

Has child received any vaccinations? ❑ Yes ❑ No

If yes, which ones and list any reactions _____

_____

Has child received any antibiotics? ❑ Yes ❑ No If yes, how many times and list reason _____

_____

Any difficulty with breastfeeding? ❑ Yes ❑ No If yes, please explain _____

_____

Any difficulty with bonding? ❑ Yes ❑ No If yes, please explain _____

_____

Any behavioral problems? ❑ Yes ❑ No If yes, please explain _____

_____

Any night terrors, sleepwalking or difficulty sleeping? ❑ Yes ❑ No If yes, please explain _____

_____

Age child began daycare _____ Average number of hours of TV per week _____

Does your child seem normal for their age? ❑ Yes ❑ No If no, please explain _____

_____

FAMILY HISTORY REVIEW

Check those involving immediate family and add identification: M=Mother; F=Father; S=Siblings; G=Grandparents

❑ Cancer, type _____ ❑ M ❑ F ❑ S ❑ G

❑ Depression ❑ M ❑ F ❑ S ❑ G

❑ Diabetes ❑ M ❑ F ❑ S ❑ G

❑ Back Problems ❑ M ❑ F ❑ S ❑ G

❑ Heart Disease ❑ M ❑ F ❑ S ❑ G

❑ Liver Disease ❑ M ❑ F ❑ S ❑ G

❑ High Blood Pressure ❑ M ❑ F ❑ S ❑ G

❑ High Cholesterol ❑ M ❑ F ❑ S ❑ G

❑ Lung Problems ❑ M ❑ F ❑ S ❑ G

❑ Scoliosis ❑ M ❑ F ❑ S ❑ G

❑ Neck Problems ❑ M ❑ F ❑ S ❑ G

❑ Osteoporosis ❑ M ❑ F ❑ S ❑ G

❑ Seizures ❑ M ❑ F ❑ S ❑ G

❑ Osteoarthritis ❑ M ❑ F ❑ S ❑ G

❑ Rheumatoid Arthritis ❑ M ❑ F ❑ S ❑ G

❑ Other _____

_____

WHAT DO YOU KNOW ABOUT CHIROPRACTIC?

Do you know what a subluxation is? ☐ Yes ☐ No Do any of your friends or relatives see a chiropractor? ☐ Yes ☐ No

If yes, do they use chiropractic for ☐ Health maintenance/optimization ☐ Health problems ☐ Both

Are you seeking chiropractic for ☐ Health maintenance/optimization ☐ Health problems ☐ Both

What would you like to gain from chiropractic care? _____

_____

Are there other health concerns or anything else you'd like us to know about your child? _____

_____

CONSENT

I understand that I am directly and fully responsible to Rivertown Family Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____

Parent's / Guardian's Signature Date

_____ _____

Doctor Signature Date