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# Pediatric Form

Child's Name: ____________________ Age: __________ Date: MM/DD/YYYY

Address: ____________________ City: __________ Prov: _____ Postal Code: __________

Home Phone #: (    ) __________ Birth Date: MM/DD/YYYY __________ Male ☐ Female ☐

Parent's Name: ____________________

Has your child ever seen a chiropractor before? Yes ☐ No ☐ If so, when? __________

Reason for consulting our office: ____________________

Who referred you to our office? ____________________

Amount of Health Coverage for: Chiropractic __________ Massage __________ Orthotics __________

## Why this Form is Important

The vast majority of our pediatric patients have experienced literally dozens of impacts that could cause subluxated vertebrae. Subluxated vertebra can cause irritation to different fibers within nerves that can affect any organ or tissue, causing conditions now or in the future. Depending on the type and degree of the subluxated vertebra, the nerve pressure can be constant or occasional. Our goals are to address the issues that brought you to this office and offer your child the opportunity of improved health potential and wellness services in the future. Our only method is specific adjustments to correct vertebral subluxations. We believe the greatest Doctor is the one already inside each of our patients and we only help to maximize their inherent healing power without the use of drugs or surgery.

## Birth Story

How long was labor? __________ How long did mother actually push? __________ Was mother induced? Yes ☐ No ☐

Nerve block? Yes ☐ No ☐ C-section? Yes ☐ No ☐ Head pulled? Yes ☐ No ☐ Forceps/vacuum? Yes ☐ No ☐

Additional comments: ____________________

## Childhood Illnesses

List any illnesses experienced: ____________________

List all current medications: ____________________

Has your child received vaccinations? All ☐ Some ☐ None ☐ Has your child had any surgeries? Yes ☐ No ☐

## Falls

Has your child fallen/jumped from a height over three feet? (ie. crib, bunk bed, tree) Yes ☐ No ☐

When was the most recent fall? __________ Any care given? __________

And the fall before that? __________ Any care given? __________

## Accidents

Has your child been involved in a motor vehicle accident as a passenger? Yes ☐ No ☐

Briefly describe: ____________________

Any treatment received? ____________________

## Sports/Recreation

What sports or recreational activities does your child do? ______________________________

When was the most recent stress, strain, or injury while doing these activities? ____________________

Any care given? ______________________________

## Current Health Concerns

Please check any symptoms that your child has or has had previously:

| | | | |
|---|---|---|---|
| ☐ Headaches/Migraines | ☐ Asthma | ☐ Sleep problems | ☐ Weight problems |
| ☐ ADD/ADHD | ☐ Postural Imbalance | ☐ PDD/Autism | ☐ Seizures |
| ☐ Frequent colds | ☐ Allergy/Sinus problems | ☐ Bedwetting | ☐ Ear infection |
| ☐ Colic | ☐ Digestive problems | ☐ Scoliosis | ☐ Growing/Back problems |

Comments: ______________________________

______________________________

______________________________

List any allergies: ______________________________

List any genetic disorders: ______________________________

List any other conditions: ______________________________

**The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine my child for evaluation.**

**Parent's Signature:** ______________________________ **Date:** ____________________