Pediatric Form

Today's Date: _______________

CHILD'S INFORMATION

Childs Name____

Date of Birth _____/_____/______ Birth Height: __________ Birth Weight: __________

Age: ________ Current Height: __________ Current Weight: __________

Address ______________________________ City _______________ State _____ Zip __________

Mother's Name: ______________________ DOB____/____/____ Mother's Mobile ________________

Father's Name: ______________________ DOB ____/____/____ Father's Mobile ________________

Who is responsible for this bill? ____

Father's Email: _________________________ Mother's Email: _________________________

Pediatrician/Family MD ______________________________ City/State ____________________

Last Visit: ____/____/____ Reason for visit to Doctor: ______________________________

CHILD'S HEALTH PROFILE

Why is this important? As a family chiropractic office, we focus on your child's ability to be healthy. Our goals are fist to address the reason that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness service.

Purpose of this visit: ☐ Illness ☐ Injury ☐ Accident ☐ Sleeplessness ☐ Well Check-up

Please explain: ____

If your child is experiencing Pain/Discomfort please identify where and for how long: ____________________

____

When did the Problem first begin? Date ___/___/___ ☐ Unknown ☐ Gradual ☐ Sudden

Have they had this problem before? ☐ Yes ☐ No If yes, when? ____________________

Is this interfering with: ☐ Sleep ☐ School ☐ Walking ☐ Other ____________________

Have you seen any other doctors for this problem? ☐ No ☐ Yes

If yes, whom? ______________________________ When: ________________

How is this problem NOW?:

☐ On & Off ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ Rapidly Worsening

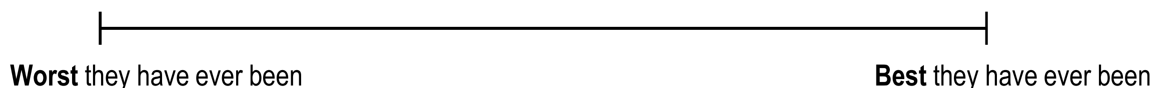
Number of doses of antibiotics your child has taken: _______ Past 6 months _______ Reason ____________________

List prescriptions your child is currently taking? ______________________________

List OTC medications or supplements your child is currently taking: ______________________________

List any surgeries your child has had: ______________________________

How would you rate your child's overall health?



Worst they have ever been **Best** they have ever been

Put an X on the line where you perceive they are overall.

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Pediatric Form

CHILD'S PAST HISTORY

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering the following questions will give us information that will allow us to better assess the challenges to your child's health potential.

Pregnancy:

Were there any complications to the pregnancy? ____________________

Was Mom on any prescriptions or OTC medications? ☐ Yes ☐ No If yes, please list and explain: ____________________

____

Did Mom or Dad smoke during pregnancy? ☐ Yes ☐ No Who? ____________________

Was baby ever in Breech position? ☐ Yes ☐ No How many ultrasounds were performed? __________

Birth and Delivery:

Where was baby born? ☐ Home ☐ Hospital ☐ Birthing Center ☐ Other: ____________________

Was the delivery: ☐ Vaginal ☐ C-Section Where any devices used? ☐ Forceps ☐ Vacuum

How long was labor? ______________ How was delivery? ____________________

Was oxytocin/pitocin used? ☐ Yes ☐ No Was an epidural used? ☐ Yes ☐ No

Infancy & Childhood:

Was infant/child vaccinated? ☐ Yes ☐ No Any adverse reactions? ☐ Yes ☐ No

If yes, to which vaccines? ____________________

What were the reactions? ____________________

Was there any prolonged use of medications or inhaler? ☐ Yes ☐ No If yes, list and explain: ____________________

____

Did infant/child suffer any traumas (falls, injury, car accident, emotional)? ☐ Yes ☐ No If yes, explain: ______________

____

Did they suffer any childhood illnesses? ____________________

Adolescence:

Any prolonged use of meds in older childhood or adolescence? ☐ Yes ☐ No If yes, list and explain: ______________

____

Has your adolescent suffered any emotional or behavioral traumas? ☐ Yes ☐ No If yes, explain: ______________

____

Has your adolescent ever sustained an injury playing organized sports? ☐ Yes ☐ No If yes, explain: ______________

____

Has your adolescent ever been injured in a car accident? ☐ Yes ☐ No If yes, explain: ______________

____

Any other adolescent or teenage issues we should be aware of? ☐ Yes ☐ No If yes, explain: ______________

____

Continued on next page . . .

Pediatric Form

CHILD'S PAST HEALTH HISTORY

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Chronic Earaches
- ❑ Sinus Trouble
- ❑ Asthma
- ❑ Colds/Flu
- ❑ Bed Wetting
- ❑ Digestive Disorders
- ❑ Poor Appetite
- ❑ Stomach Aches
- ❑ Colic
- ❑ Reflux
- ❑ Constipation
- ❑ Diarrhea
- ❑ Orthopedic Problems
- ❑ Neck Problems
- ❑ Arm Problems
- ❑ Leg Problems
- ❑ Joint Problems
- ❑ Backaches
- ❑ Muscle Pain
- ❑ Growing Pains
- ❑ Poor Posture
- ❑ Scoliosis
- ❑ Walking Trouble
- ❑ Broken Bones
- ❑ Anemia
- ❑ Hernia/Ruptures
- ❑ Seizures/Convulsions
- ❑ Heart Trouble
- ❑ Hypertension
- ❑ Behavioral Problems
- ❑ ADD/ADHD
- ❑ Sleeping Problems
- ❑ Fall from height over 3'
- ❑ Fall down stairs
- ❑ Other: ___________________
- ❑ Other: ___________________

❑ Allergies: ____

❑ Other: ____

____

YOUR GOALS FOR YOUR CHILD'S CARE:

- ❑ Feel better quickly – Pain relief
- ❑ Have a healthier spine
- ❑ Feel better and prevent return of problems
- ❑ Optimum health and to live a healthier lifestyle

PARENTAL CONSENT:

I understand that I am directly and fully responsible to Austin Life Chiropractic for all fees associated with the care my child receives. The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction. 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 or Legal Guardian's Signature **Date Completed**

____ ______ / ______ / ______

Doctor's Signature **Date Form Reviewed**