

# Welcome to Spinal Corrective Center

## *Pediatric History Form*

Today's Date: \_\_\_/\_\_\_/\_\_\_ Home Ph. # \_\_\_\_\_

Patient's Name: \_\_\_\_\_

What patient prefers to be called: \_\_\_\_\_

Parents / Guardian Names: \_\_\_\_\_

\_\_\_\_\_  
Mailing (Street) Address:

\_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Parent's email address (for patient newsletter): \_\_\_\_\_

\_\_\_\_\_  
Child's Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_M \_\_\_F S.S. # \_\_\_\_\_

\_\_\_\_\_  
How did you learn about our office?

\_\_\_\_\_  
Previous Chiropractic Care? \_\_\_ Yes \_\_\_ No

Approximate Last Visit Date: \_\_\_\_\_

Please check reasons 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're 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:

\_\_\_ Headaches \_\_\_ Postural Imbalance \_\_\_ Asthma \_\_\_ Allergies \_\_\_ Ear

Infection \_\_\_ Scoliosis

\_\_\_ ADD/ADHD \_\_\_ PDD/Autism \_\_\_ Seizures \_\_\_ Growing/Back Pains \_\_\_ Car Accident

\_\_\_ Digestive Problems \_\_\_ Frequent Colds \_\_\_ Sinus Problems \_\_\_ Bedwetting

\_\_\_ Colic

Other: \_\_\_\_\_

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 her/her lifetime: \_\_\_\_\_

List medications: \_\_\_\_\_

Prenatal History:

Adopted? \_\_\_ No \_\_\_ Yes

Complications during pregnancy? \_\_\_ No \_\_\_ Yes

List: \_\_\_\_\_

Ultrasounds during pregnancy? \_\_\_ No \_\_\_ Yes Number: \_\_\_\_\_

Medications/drugs/caffeine during pregnancy? \_\_\_ No \_\_\_ Yes

List: \_\_\_\_\_

Cigarette / Alcohol use during pregnancy? \_\_\_ No \_\_\_ Yes

Location of Birth: \_\_\_ Hospital \_\_\_ Birthing Center \_\_\_ Home

Birth Intervention: \_\_\_ Mother induced \_\_\_ Mother medicated (Pitocin, etc.) \_\_\_

Ceasarian 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:

---

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child?

\_\_\_ No \_\_\_ Yes List:

---

Is/Has your child been involved in any high impact or contact type sports (I.e., soccer, football, gymnastics, hockey, baseball, cheerleading, martial arts, etc.)? \_\_\_ No \_\_\_ Yes List: \_\_\_\_\_

Has your child been seen on an Emergency Basis? \_\_\_ No \_\_\_ Yes

List: \_\_\_\_\_

Prior Surgery? \_\_\_ 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)      \_\_\_/\_\_\_/\_\_\_