CHIROPRACTIC &
VITALITY STUDIO

PEDIATRIC HEALTH HISTORY FORM

Today's Date: ___/___/___

Child's Name: _____

What does your child prefer to be called: _____

Parents / Guardian Names: _____

Mailing (Street) Address: _____

City: _____ State: _____ Zip Code: _____

Parent's email address (for office updates): _____

Home Phone _____ Parent's Mobile Phone: _____

Child's Birth Date: ___/_____/_____ Age: _____ Sex: M___ F___

How did you learn about our office? _____

Previous chiropractic care? Yes_____ No_____ Approximate Last Visit Date: _____

Does your child have health insurance? Yes _____ No _____

Please check reasons for pursuing chiropractic care for your child:

____ S/He is continuing ongoing care from another chiropractor.

____ I am interested in wellness and natural health care for my child.

____ 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.

____ S/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 us what you do.

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 ____ Poor Posture ____ Asthma ____ Allergies ____ Ear Infection ____ Scoliosis

____ ADD/ADHD ____ PDD/Autism ____ Seizures ____ Growing/Back Pains ____ Car Accident

____ Digestive Problems ____ Frequent Colds ____ Sinus Problems ____ Bedwetting ____ Colic

Other: _____

Prenatal History:

Adopted? No___ Yes___ Ultrasounds during pregnancy? No___ Yes___ How many? _____

Cigarette / Alcohol use during pregnancy? No___ Yes_____

Location of Birth: Hospital___ Birthing Center___ Home___

Medications/drugs during pregnancy? No___ Yes___ List: _____

Birth Intervention: Mother induced___ Mother medicated (Pitocin, etc.)___

Caesarian Section___ Forceps___ Vacuum Extraction___ Baby given medication after delivery: _____

Post birth complications for baby:_____

Genetic disorders or disabilities? No___ Yes___ List:_____

Breast Fed? No___ Yes___ How Long? _____ Formula Fed? No___ Yes___

Medical History

Food allergies or intolerances? No___ Yes___ List: _____

Number of doses of antibiotics your child has taken:

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

List reasons: _____

List prescription or over-the-counter medications now taken by child:

_____

Known allergies: _____

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). List any falls:

_____

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.

X _____ _____/_____/_____

(Parent / Guardian Signature) (Date)