PENNEY FAMILY CHIROPRACTIC

Pediatric History Form

Date:____/____/____ Child's Name: _____
Parent/Guardian Names: _____
Address: _____
City:_____ State:_____ Zip Code:_____
Home Phone (parental):_____ Cell Phone:_____
Email address:_____
Birth Date: ____/____/____ Age:_____ Birth Weight:_____
Current Weight:_____ Sex: M F

REASON FOR PURSUING CHIROPRACTIC CARE

_____ 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.
_____ I want to improve my child's immune function.
_____ I have no idea why we're here. Please explain to me what you do for children.
_____ She/He has a specific condition that concerns me.

Explain condition/symptom:
_____

_____

How did you hear about our office? _____

PRESENT HISTORY

In order to understand your child's current level of health, please check any of the following body signals which your child has or has had previously.

☐Ear Infections	☐Allergies	☐Asthma	☐Colic	☐Chronic colds/cough
☐Headaches	☐ADHD	☐Bed Wetting	☐Seizures	☐Recurring Fevers
☐Constipation	☐Diarrhea	☐Rashes	☐Scoliosis	☐Car Accident(s)
☐Stomach/Digestive	☐Temper Tantrums	☐Learning Disorder		☐Sleeping Problems

☐Other (please describe):_____

List Prescription or Over the Counter Medications Now Taken:
_____

_____

Known Allergies:
_____

Immunization History:_____
How many prescriptions of antibiotics has your child taken in the last 6 months?_____
How many in his/her lifetime (estimate):_____

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 HISTORY

Birth Intervention:
____ Mother Induced ____ Mother Medicated (Pitocin, etc.) ____ Caesarian Section
____ Forceps _____ Vacuum Extracted _____ Baby given medication after delivery

Complications during delivery?
List: _____
Breast Fed? ____ No ____ Yes How Long? _____
Formula Fed? ____ No ____ Yes How Long? _____
Genetic Disorders / Disabilities? _____ No _____ Yes
List: _____

According to the National Safety Council, approximately 50% of infants fall head first from a high place (bed, changing table, down stairs etc.) during the first year of life.
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: _____

AUTHORIZATION FOR CARE OF A MINOR

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 objective is specific adjusting to correct vertebral subluxations. 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:____/____/____