Chiropractic Alchemy

Pediatric Chiropractic History Form

Today's Date _____/_____/_____

Name_____ Date of Birth _____/_____/_____

Address _____City _____ State _____ Zip _____

Home phone _____ Work/Cell _____

Mother (name) _____ Father (name) _____

Birth Height: _____ Birth Weight: _____
Current Height: _____ Current Weight: _____ Age: _____

Ever been under chiropractic care? _ No _ Yes: Who/When?
_____

PREGNANCY HISTORY:
Third Trimester Presentation: _____Vertex _____Breech _____Transverse _____Face/Brow
Type of Birth: _____Normal Vaginal ____Forceps _____Cesarean ____Suction Cap or Vacuum
Location: _____Home _____Hospital _____Birthing Center _____Other:_____
Problems during Pregnancy:
_____
Problems during Labor/Delivery:
_____

INFANT HISTORY:
Infant feeding: _____Breast _____Bottle If Bottle; which Formula?
_____
Number of Hours sleep per night _____
Quality of Sleep: _____Good _____Fair _____Poor

List all IMMUNIZATIONS your child has had:
_____
Has your child ever been treated at the emergency room? _____ If yes; please explain
_____
Has your child ever been hospitalized? _____ If yes; please explain
_____
Has your child ever had any surgeries? _____ If yes; please explain
_____
Is your child currently on any medication? _____ If yes; please list:
_____

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HAS YOUR CHILD EVER EXPERIENCED:

_ Headaches	_ Emotional upset	_ Digestive Disorders	_Behavioral concerns
_ Dizziness	_ Neck Problems	_ Poor Appetite	_ ADD/ADHD
_ Fainting	_ Arm Problems	_ Stomach Aches	_ Ruptures/Hernia
_ Seizures	_ Leg Problems	_ Reflux	_ Muscle Pain
_ Scoliosis	_ Joint Problems	_ Constipation	_ Growing Pains
_ Diarrhea	_ Backaches	_ Chronic earaches	_ Sinus Trouble
_ Asthma	_ Hypertension	_ Poor posture	_ Heart problems
_ Anemia	_ Colds/Flu	_ Walking Trouble	_ Bed Wetting
_ Colic	_ Broken Bones	_ Sleeping Problems	_Dietary concerns

_ Other: _____

HAS YOUR CHILD EVER EXPERIENCED THE FOLLOWING SPINAL TRAUMAS:

_ Fall in baby walker	_ Fall from bed or couch	_ Fall off skateboard or skates
_ Fall from crib	_ Fall off swing	_ Fall off bicycle
_ Fall from high chair	_ Fall off slide	_ Fall down stairs
_ Fall from changing table	_ Fall off monkey bars	

_ Other: _____

Has your child ever sustained an injury playing sports? _____ If yes; please explain_____

Has your child ever sustained an injury in an auto accident? _____ if yes; please explain_____

CHILD'S CURRENT:

Purpose of this visit: _____Wellness _____Health concern _____Other: _____

If due to Health concern, please fill out:

1. Onset of Problem: Date ____/____/_____ _____Unknown _____Gradual _____Sudden
2. Ever had this problem before? _ No _ Yes If yes when?

_____

3. Any medication taken for this problem? No Yes:

_____

4. Have you seen any other doctors for this problem? No Yes:

_____

5. How is this problem NOW: _Rapidly Improving _Improving Slowly _About the Same _Gradually Worsening _On & Off

I hereby authorize this office and its Doctor(s) to administer care, as they so deem necessary to my son/daughter

_____

Parent's or Legal Guardian's Signature _____

Printed Name_____ Date _____