

MARBLE CITY FAMILY CHIROPRACTIC

Pediatric History Form: AGES 0-9

As a family chiropractic office, we focus on your child's ability to be healthy. Our goals are first to address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness services.

Whom should we thank for referring you to this office _____

PATIENT DEMOGRAPHICS: Today's Date: ___/___/___ HR# _____

Child's Full Name: _____ Name she/he go by: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Child's Social Security: _____

Age: _____ Height: _____ Weight: _____ Date of Birth: ___/___/___ Sex: _____

Names and Ages of Siblings: _____

Mother/Guardian Name: _____ Mother/Guardian's Mobile Number: _____

Father/Guardian Name: _____ Father/Guardian's Mobile Number: _____

Parent/Guardian E-mail address: _____

Insurance:

Insured's Name: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Insured's Social Security Number: _____

Child's Current Problems:

Purpose of this visits: ___ Wellness Check-up ___ Injury or Accident ___ Other

Please Explain: _____

If your child is experiencing **Pain/Discomfort**, please identify where and for how long

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

2. Ever had this problem before? ___ No ___ Yes If yes when? _____

3. Any bowel or bladder problems since this problem began? If yes, (Describe)

4. Have you seen any other doctors for this problem? ___ No ___ Yes If yes, who?

5. How long ago? ___ Days ___ Weeks ___ Months ___ Years

6. What were the results of past treatment? _____

7. How is the problem NOW: ___ Rapidly Improving ___ Improving Slowly ___ About the same ___ Gradually Worsening ___ On and Off

8. Please list any medication taken for this problem:

9. Does it interfere with your (circle all that apply): Work/School Sleep Daily routine Exercise

10. Is your pain **sharp, dull throbbing, burning, numb** and/or **achy**? _____

11. Is your pain worse in the **morning, evening**, and/or **after specific activity**?

12. Has your child ever sustained an injury playing organized sports? _____ If yes; please explain _____

13. Has your child ever sustained an injury in an auto accident? _____ If yes; please explain _____

Has your Child Ever Suffered from: mark Y for Yes or N for No

___ Headaches ___ Orthopedic Problems ___ Digestive Disorders ___ Behavioral Problems

___ Dizziness ___ Neck Problems ___ Poor Appetite ___ ADD/ADHD

<input type="checkbox"/> Fainting	<input type="checkbox"/> Arm Problems	<input type="checkbox"/> Stomach Aches	<input type="checkbox"/> Ruptures/Hernia
<input type="checkbox"/> Leg Problems	<input type="checkbox"/> Reflux	<input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Heart Troubles
<input type="checkbox"/> Joint Problems	<input type="checkbox"/> Constipation	<input type="checkbox"/> Growing Pains	<input type="checkbox"/> Chronic Earaches
<input type="checkbox"/> Backaches	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Poor Posture
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Asthma	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Anemia
<input type="checkbox"/> Colds/Flu	<input type="checkbox"/> Walking Trouble	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Colic
<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Fall in baby walker	<input type="checkbox"/> Fall off bicycle
<input type="checkbox"/> Fall from bed/couch	<input type="checkbox"/> Fall from Crib	<input type="checkbox"/> Fall off swing	<input type="checkbox"/> Fall down stairs
<input type="checkbox"/> Fall from high chair	<input type="checkbox"/> Fall off slide	<input type="checkbox"/> Fall off monkey bars	<input type="checkbox"/> Fall from changing table
<input type="checkbox"/> Fall skateboard/skates		<input type="checkbox"/> Allergies to _____	

Other: _____

Chiropractic History:

Have you ever been to a chiropractor before? Yes No Date of last chiropractic visit: _____

Are other family members under chiropractic care? Yes No Who? _____

The vast majority of our patients have experience dozens of falls of impacts (sports/hobby/work related) that could cause Vertebral Subluxations. Help us discover a few of yours.

- Which of the following sports have you been involved in (circle all that apply)? Football, Basketball, Soccer Running, Gymnastics/Cheerleading, Martial Arts, Other: _____
- Have you ever... Fallen down the stairs, Slipped/Fell on the ground (or ice), Had a sports injury, Broken Bone: If so, which one: _____
- Have you been involved in any car accidents/fender benders? Yes No Date: _____
- Name of Family Doctor/Pediatrician: _____
- Have you ever been seen on an emergency basis? Yes No Reason/Date: _____
- Exercise: None ___ 1-3x week ___ 4-7x week ___ Only PE ___ Sports ___ Other: _____
- Please list any past surgeries (or traumas) and dates: _____
- How many hours of sleep do you get? _____ Do you have trouble falling asleep? _____
- Do you sleep on your stomach? _____

Dietary/Medication History:

- Please list number of doses of antibiotics you have taken:
 - During the past 6 months: _____ During your lifetime: _____
- Please list name and number of doses of any medications (prescription or Over the Counter) taken:
 - During the past 6 months: _____
 - During your lifetime: _____
- Please list all medications you take: _____
- Please list any vitamins/supplements you take: _____
- Vaccination History: _____ Any reaction to them? _____
- Do you consume (check all that apply): Soda ___ White Flour products ___ Fast Foods ___ Fried Foods ___ Sweets ___
- Dairy/Milk products ___ Meat/Fish ___
- Do you have any food allergies (please list them): _____

YOUR BIRTHING PROCESS:

- Location of Birth: Home ___ Birthing Center ___ Hospital (CNM or OB?) _____
- Number of attendant: _____
- Please list any complication during pregnancy/delivery: _____

- Medications during pregnancy/delivery: _____
- Number of ultrasounds during pregnancy: _____
- Birth intervention: Forceps _____ Vacuum _____ Caesarian: planned or emergency: _____
- How long we're you breastfed? _____
- We're all developmental milestones met on time? _____
- Number of weeks Gestation: _____ Birth Weight: _____ Birth length: _____ APGAR scores _____.

Feeding History:

- Breast Fed: ___N ___Y How long? _____ Any problems? _____
- Formula fed: ___N ___Y How long? _____ Type: _____
- Did your baby have colic and/or reflux? ___N ___Y Introduced to solids at _____ months, Cow's milk at _____ months
- Food/ Juice allergies or intolerances ___N ___Y List: _____

Developmental History:

- Number of hours sleeping per night: _____ Quality of sleep: Good Fair Poor
- When did they stop napping (if so) _____
- At what age was your child able to:
 - _____ Respond to sound _____ Cross crawl _____ Sit Up
 - _____ Respond to visual stimuli _____ Stand alone
 - _____ Hold head up _____ Walk alone
- According to the National Safety Council, approximately 50% of children fall head first from a high place during their first of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child? ___N ___Y
- Is/has your child been involved in any sports? ___N ___Y Type: _____
- Has your child ever been involved in a car accident? ___N ___Y Date: _____
- Has your child been seen on an emergency basis? ___N ___Y Reason and Date: _____
- Other traumas not described above, including falls from a height over 3 feet? _____
- Prior surgery: ___N ___Y Type and Date: _____
- Please give us any other health information you feel would be helpful: _____

I understand that I am directly and fully responsible to MARBLE CITY FAMILY CHIROPRACTIC for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. 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 condition 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 the office.

Parent or Legal Guardian's Signature

Date

Doctor Signature

Date