Pediatric History Form

It is a pleasure to welcome you to our family of happy and healthy chiropractic kids. Please let us know if there is any way we can make you and your family feel more comfortable. Many types of stressors (physical, mental, and chemical) can interfere with your child's growing brains, spine and nervous system. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Child's Name: _____ Birth Date: ___/___/____

Male/ Female (Circle one) Weight: _____lbs. Height_____ft_____in. Phone #_____

Address:_____City:_____

State:_____ Zip:_____ Parent/ Guardian:_____

Referred by:_____

Reason for pursuing care: ☐ maintenance ☐ improved health ☐ problem:_____

Family history: _____

Check any of the following conditions that currently apply:

___ Ear infections	___ Scoliosis	___ Chronic colds	___ Headaches
___ Allergies	___ Digestive problems	___ ADHD/ADD	___ Recurring Fevers
___ Colic	___ Growing/ back pain	___ Bed wetting	___ Temper tantrums
___ Reflux	___ Tonsillitis	___ Asthma	___ Eczema/Psoriasis
___ Autism/Spectrum	___ Developmental Delays	___ Constipation	___ Diarrhea
___ Seizures	___ Asthma	___ Sleep Issues	___Nursing/Latch Issues

List any other health problems: _____

Previous Chiropractic Care? Y/ N Last Visit: ___/___/___
Name of Chiropractor: _____
Name of Pediatrician: _____ Last Visit: ___/___/___

What are the most significant measures you have taken to date to improve your child's present health challenge? Please list all the healthcare practitioner's seen, treatments rendered, and any results experienced.

_____
_____
_____

Please list any and all other concerns regarding your child's health and whether or not you feel they are related to your child's primary reason for being seen in our office today.

_____
_____

Did you know that the persistent use of antibiotics can lead to an early onset of gastrointestinal tract distress leading to overgrowth of intestinal yeast? Did you also know that chronic use of antibiotics can lead to antibiotic resistant bacteria?
Please list any and all prescription medications that your child is presently using and has used on more than one occasion.

# of Doses of antibiotics your child has taken: Past 6 months_____ Total lifetime _____
_____
_____
_____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.) _____

Prenatal History

Name of Obstetrician/ Midwife: _____

Weeks Pregnant at time of Delivery _____

Complications during pregnancy/ delivery? Y/N

Explain:_____

_____

Induced into Labor ? Y/N Epidural? Y/N

Ultrasounds during pregnancy? Y/N How many?_____

Medications taken during pregnancy/ delivery? Y/N List:_____

Cigarette/ Alcohol use during pregnancy? Y/N

Location of birth (circle one): Hospital Birth Center Home

Birth Intervention (circle one): Forceps Vacuum Extraction Caesarian Section

If Caesarian Section, was it: _____Emergency or _____ Planned (check one)

Genetic disorders/ disabilities? Y/N List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____-_____

Vaccinated: Y/ N Adverse Vaccine Reactions Y/N Explain_____

Vitamin K shot Y/N

Feeding History

Breast Fed: Y/N How long? _____ Formula Fed: Y/N How long? _____ Type:_____

Introduced to: Solid Foods @_____months Cow's milk @_____months

Rice Cereal Y/N @ _____ months

Allergies or intolerances: Y/N List: _____

Developmental History

Your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).
At what age was your child able to:

_____ Respond to stimuli _____ Cross Crawl _____ Stand alone

_____ Respond to visual stimuli _____Hold head up _____ Walk alone

_____ Sit up

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs)

Did your child have a fall similar to what was described above? Y/N
Explain:_____

Has your child been involved in any sports? Y/N List: _____

_____

Has your child been seen by a physician on an emergency basis? Y/N Explain:_____

_____

Other traumas not described above? _____

Lifestyle

Does your child: ☐ Eat health foods (organic products, etc.) ☐ Drink water

☐ Take vitamins Type: _____ ☐ Take probiotics

Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Is there anything else you would like us to know about your child? _____

_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Parent, Guardian or Personal Representative Date

_____ _____
Print Name of Parent, Guardian or Personal Representative Relationship to Patient

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke.

The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery.

Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit. I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:_____

Parent or Guardian: _____ Signature:_____ Date:_____

Witness Name: _____ Signature:_____ Date:_____