Pediatric History Form

(Please print, all information is confidential)

Dear New Patient:
It is our pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. 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.

Patient's Name: ______________________________ Referred by: ____________________

Address: ______________________________ City: ____________ State: _____Zip:_______

Home Ph: ______________ Work Ph: ______________ Cell Ph: ____________________

Other Ph: _____________ E-mail: ____

Sex: ❍Male ❍Female DOB: ___________ Age: ______________ Weight: _______Height:_______

Names of Parents / Guardians: ____

Purpose for Contacting Us? ____

Other doctors seen for this condition? ❍YES ❍NO, Doctors' names and prior treatments:__________________

____

Other health problems? ____

Check any of the following conditions your child has suffered from during the past six months:

❍ Ear Infections	❍ Scoliosis	❍Seizures	❍Recurring Fevers
❍Asthma / Allergies	❍ Digestive Problems	❍ ADHD	❍Temper Tantrums
❍ Colic	❍ Growing / Back Pains	❍ Car Accident	❍ Other ___________
❍ Headaches	❍ Bed Wetting	❍ Chronic Colds	

Family History: ____

____

Previous Chiropractor: ____

Date of last visit: _______/_______/_______ Reason: ______________________________

Name of Pediatrician: ____

Date of last visit: _______/_______/_______ Reason: ______________________________

Are you satisfied with the care your child has received there? ❍YES ❍NO

Number of doses of Antibiotics your child has taken:

During the past six months: ___________, Total during his/her lifetime: ______________

Number of doses of other Prescription Drugs your child has taken:

During the past six months: ___________, Total during his/her lifetime: ______________

Was your child vaccinated? ❍YES ❍NO

Prenatal History:

Name of obstetrician / midwife: ____

Complications during pregnancy? ❍YES ❍NO, List: ______________________________

Ultrasounds during pregnancy? ❍YES ❍NO, Number: ______________________________

Medications during pregnancy / delivery? ❍ YES ❍NO, List: ______________________________

Cigarette / Alcohol use during pregnancy? ❍YES ❍NO

Location of birth: ______________________________ ❍Hospital ❍Birthing Center ❍Home

Birth intervention? ❍Forceps ❍Vacuum extraction ❍C-Section Emergency❍or Planned❍?

Complications during delivery? ❍YES ❍NO, List: ______________________________

Genetic disorders or disabilities? ❍YES ❍NO, List: ______________________________

Feeding History:

Breast Fed? ❍YES ❍ NO, How Long? ___________________

Formula Fed? ❍YES ❍NO, How Long? __________________

Introduced to solids at: ___________ months, cow's milk at ____________months

Food / juice allergies or intolerances: ❍YES ❍NO, List: ______________________________

____

Developmental History:

During the times listed below, 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 sound _________ Respond to visual stimuli _________ Hold head up _________ Sit up

_________ Crawl _________ Stand alone _________ Walk alone

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, etc.). Was this the case with your child? ❍YES ❍NO

Is or has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ❍YES ❍NO, List: ______________________________

____

Has your child ever been involved in a car accident? ❍Yes ❍No, List: ______________________________

Other traumas not described above? ❍Yes ❍No, List: ______________________________

Prior surgery: ❍YES ❍NO, List: ______________________________

Age of first Menstruation: ________________

Childhood Diseases:

Chicken Pox: ❍YES ❍NO, Age: ______ Mumps: ❍YES ❍NO, Age: ______

Rubella: ❍YES ❍NO, Age:______ Rubeola: ❍YES ❍NO, Age: ______

Whooping Cough: ❍YES ❍NO, Age: ______ Other: ❍YES ❍NO, Age: ______

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctors to administer care to ______________________(child's name) as they deem necessary. I do clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: ____ Witnessed: _________________________ Date: ______________

ROCKET CITY CHIROPRACTIC

<u>THIS FORM CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE</u>

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working toward the same objective.

Chiropractic has only one goal. It is important for each patient to understand both the objective and the method that will be used to attain it. This will prevent confusion or disappointment.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of the health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate interference to the expression of the body's innate wisdom. Our only method is the specific adjustment of vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal, physical, mental and social well-being, not merely the absence of disease of infirmity.

Vertebral Subluxations: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

In case of emergency, notify ___________________________________ Phone #_________________________

___________________________________have read and fully understand the above statements. All questions
(Print Name)
regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on that basis. _______________________________ __________________
(Signature) *(Date)*

COMPLETE IF THE PATIENT IS A MINOR CHILD: Child's name: ____________________________________

____________________________________, being the parent or legal guardian of the aforementioned child
(Parent/Guardian Print Name)
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive

chiropractic care. ____ _________________________
(Parent's/Guardian's Signature) *(Date)*