

PEDIATRIC HISTORY FORM

Dear New Patient,

It is a 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 or 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 NAME: _____ BIRTH DATE: _____

ADDRESS: _____

WEIGHT: _____ HEIGHT: _____ MALE OR FEMALE: _____

MOTHER'S NAME: _____ FATHER'S NAME: _____

HOME PHONE: _____ WORK PHONE: _____

INSURANCE COMPANY: _____ ID NUMBER: _____

NAME OF INSURED: _____ INSURED'S DOB: _____

PURPOSE FOR YOUR VISIT: _____

OTHER DOCTORS SEEN FOR THIS CONDITION: YES NO DR'S NAME: _____

PRIOR TREATMENTS: _____

OTHER HEALTH PROBLEMS: _____

CHECK ANY OF THE FOLLOWING CONDITIONS YOUR CHILD HAS SUFFERED FROM IN THE LAST 6 MONTHS:

- | | | | | |
|---|---|---------------------------------------|---|---|
| <input type="checkbox"/> EAR INFECTIONS | <input type="checkbox"/> SCOLIOSIS | <input type="checkbox"/> SEIZURES | <input type="checkbox"/> CHRONIC COLDS | <input type="checkbox"/> HEADACHES |
| <input type="checkbox"/> ASTHMA/ALLERGIES | <input type="checkbox"/> DIGESTIVE PROBLEMS | <input type="checkbox"/> ADHD | <input type="checkbox"/> RECURRING FEVERS | <input type="checkbox"/> GROWING/BACK PAINS |
| <input type="checkbox"/> COLIC | <input type="checkbox"/> BED WETTING | <input type="checkbox"/> CAR ACCIDENT | <input type="checkbox"/> TEMPER TANTRUMS | <input type="checkbox"/> OTHER: _____ |

FAMILY HISTORY: _____

PREVIOUS CHIROPRACTOR: _____

DATE OF LAST VISIT: _____ REASON: _____

NAME OF PEDIATRIC/FAMILY DOCTOR: _____

DATE OF LAST VISIT: _____ REASON: _____

ARE YOU SATISFIED WITH THE CARE YOUR CHILD RECEIVED THERE? YES NO

NUMBER OF ANTIBIOTICS YOUR CHILD HAS TAKEN:

IN THE PAST 6 MONTHS: _____ TOTAL DURING HIS/HER LIFE: _____ LIST: _____

NUMBER OF DOSES OF ANTIBIOTICS YOUR CHILD HAS TAKEN:

IN THE PAST 6 MONTHS: _____ TOTAL OVERALL: _____ LIST: _____

VACCINATION HISTORY: _____

PRENATAL HISTORY:

NAME OF OBSTETRICIAN/MIDWIFE: _____

COMPLICATIONS DURING PREGNANCY? NO YES (IF YES) LIST: _____

ULTRASOUNDS DURING PREGNANCY? NO YES (IF YES) LIST: _____

MEDICATIONS DURING PREGNANCY/DELIVERY? NO YES (IF YES) LIST: _____

CIGARETTE/ALCOHOL USE DURING PREGNANCY? NO YES (IF YES) LIST: _____

LOCATION OF BIRTH: HOSPITAL BIRTHING CENTER HOME

BIRTH INTERVENTION: FORCEPS VACUUM EXTRACTION CAESARIAN SECTION, EMERGENCY OR PLANNED? _____

COMPLICATIONS DURING DELIVERY? NO YES (IF YES) LIST: _____

GENETIC DISORDERS OR DISABILITIES? NO YES (IF YES) LIST: _____

WEIGHT: _____ BIRTH LENGTH: _____ APGAR SCORES: _____

FEEDING HISTORY:

BREAST FED: NO YES (IF YES) HOW LONG? _____

FORMULA FED: NO YES (IF YES) HOW LONG? _____

INTRODUCED TO SOLIDS AT: _____ MONTHS OLD, COWS MILK AT: _____ MONTHS OLD

FOOD/JUICE ALLERGIES OR INTOLERANCES: NO YES (IF YES) LIST: _____

DEVELOPMENTAL HISTORY:

DURING THE FOLLOWING TIMES YOUR CHILD'S SPINE IS MORE VULNERABLE TO STRESS AND SHOULD ROUTINELY BE CHECKED BY A CHIROPRACTOR FOR PREVENTION AND EARLY DETECTION OF VERTEBRAL SUBLUXATION (SPINE NERVE INTERFERENCE).

AT WHAT AGE WAS YOUR CHILD ABLE TO:

_____ RESPOND TO SOUND _____ HOLD HEAD UP _____ CROSS CRAWL _____ WALK ALONE

_____ RESPOND TO VISUAL STIMULI _____ SIT UP _____ STAND ALONE

ACCORDING TO THE NATIONAL SAFETY COUNCIL, APPROXIMATELY 50% OF CHILDREN FELL HEAD FIRST FROM A HIGH PLACE DURING THEIR FIRST YEAR OF LIFE (I.E. BED, CHANGING TABLE, STAIRS, ETC).

WAS THIS THE CASE WITH YOUR CHILD? : NO YES (IF YES) LIST: _____

HAS YOUR CHILD EVER BEEN INVOLVED IN A CAR ACCIDENT? NO YES (IF YES) LIST: _____

HAS YOUR CHILD EVER BEEN SEEN ON AN EMERGENCY BASIS? NO YES (IF YES) LIST: _____

OTHER TRAUMAS NOT DESCRIBED ABOVE? NO YES (IF YES) LIST: _____

PRIOR SURGERY? NO YES (IF YES) LIST: _____

MENARCHE? NO YES (IF YES) LIST: _____

CHILDHOOD DISEASES:

CHICKEN POX NO YES AGE _____

MUMPS NO YES AGE _____

RUBELLA NO YES AGE _____

WHOOPING COUGH NO YES AGE _____

RUBEOLA NO YES AGE _____

OTHER: _____ NO YES AGE _____

AUTHORIZATION FOR CARE OF A MINOR

I HEREBY AUTHORIZE FAMILY CHIROPRACTORS OF MONTCLAIR AND ITS DOCTORS TO ADMINISTER CARE TO MY SON/DAUGHTER AS THEY DEEM NECESSARY. I CLEARLY UNDERSTAND AND AGREE THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED BY THIS OFFICE.

(PARENT/GUARDIAN PRINTED NAME)

(PARENT/GUARDIAN SIGNATURE)

(DATE)

I AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL RECORDS OR OTHER NECESSARY INFORMATION TO PROCESS CLAIMS. I ALSO REQUEST PAYMENT OF BENEFITS BE MADE DIRECTLY TO FAMILY CHIROPRACTORS OF MONTCLAIR. I AM CONSENTING TO SIGNING AN OPEN SIGN-IN SHEET EVERY VISIT ON BEHALF OF MY SON/DAUGHTER AND I UNDERSTAND THAT ANYONE WHO ENTERS THE OFFICE WILL BE ABLE TO VIEW HIS/HER NAME ON THIS SHEET. THE STATEMENTS MADE ON THIS FORM ARE ACCURATE TO THE BEST OF MY RECOLLECTION.

(PARENT/GUARDIAN PRINTED NAME)

(PARENT/GUARDIAN SIGNATURE)

(DATE)