Helping hands chiropractic

Pediatric history form (for children 12 years and younger)

It is a pleasure to welcome you to our family of happy and health chiropractic patients here at helping hands chiropractic. Please let us know if there is any way we can make you and your family more comfortable. To help us serve you better, please complete the following information.
We look forward to working with you to create better health for your family!

(Please Print)

Patient Name:_______________________________________ Name you prefer us to use:___________________________

Address:____ City:__________________ State:_______ Zip:_____________

Home Phone: ______________________________________ Cell Phone: ____

Date of Birth: ______________ Gender: □ Female □ Male Weight: _________ Height: _________ Temp: __________

Parent(s)/Guardian Name (s): _______________________________________ Referred By: _________________________

Purpose for contacting Helping Hands Chiropractic: ____

Have Other Doctors Been Seen For This Condition? □ Yes □ No If Yes, Please list doctor names and treatments: ____

____

Any other health problems? ____

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

□ Ear Infections □ Digestive Problems □ Car Accident □ Headaches

□ Asthma / Allergies □ Bed Wetting □ Chronic Colds □Growing / Back Pains

□ Colic □ Seizures □ Recurring Fevers □ Autism

□ Scoliosis □ ADD / ADHD □ Temper Tantrums □ Other: ________________

Family History of any of the above conditions:____

Previous Chiropractic Care (If Any): ____

Date of Last Visit: _________________ Reason for Visit:____

Are you satisfied with the care your child received? □ Yes □ No

If No, Why were you not satisfied? ____

Name of Pediatrician: ____ Date of Last Visit: ________________

Reason for Visit: ____

Are you satisfied with the care your child received? □ Yes □ No

Number of **Antibiotics** your child has taken during the past six months: ______ During his/her lifetime _____

Number of other **prescription medications** your child has taken during the past six months: _______________

During his/her lifetime: ______ please list: ____

____

Vaccination history: ____

Prenatal history:

Name of obstetrician/midwife: ____

Complications during pregnancy: □ Yes □ No please list: ____

Ultrasounds during pregnancy: □ Yes □ No Number: ____________

Medications during pregnancy/delivery: □ Yes □ No please list: ____________________________________

Cigarette/alcohol use during pregnancy: □ Yes □ No

Location of birth: □ hospital □ birthing center □ home

Birth intervention: □ forceps □ vacuum extraction □ caesarian section

If c-section: □ emergency □ planned

Complications during delivery: □ Yes □ No please list: ____________________________________

Genetic disorders or disabilities: □ Yes □ No please list: ____________________________________

Birth weight: _________ birth length: _________ apgar scores: ____________________________________

Feeding history:

Breast fed: □ Yes □ No how long? _____________

Formula fed: □ Yes □ No how long? _____________ what type? ______________________________

Introduced to solids at _____ months introduced to cows' milk at _____ months

Food/juice allergies or sensitivities: □ Yes □ No please list: ______________________________

____

Developmental history:

During the following developmental stages your child's spine is the most vulnerable to stresses and should routinely be checked by a chiropractic physician for prevention and early detection of vertebral subluxations (spinal nerve interference).

At what age was your child able to perform the following tasks:

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 all children fall head-first from a high place (bed, changing table, stairs, etc.) during their first year of life.

Has your child had a head first fall? □ Yes □ No please describe: ______________________________

____

Is/has your child been involved in any high impact or contact sports? (i.e. soccer, football, gymnastics)

□ Yes □ No please list: ____

Has your child been involved in a car accident: □ Yes □ No please list: _________________________

Has your child been seen on an emergency basis? □ Yes □ No please list: _______________________

Other traumas not described above? ____

any surgeries: □ Yes □ No please list: ____

Menarche: □ Yes □ No □ n/a what age: _______

Childhood diseases:

□ chicken pox age: _____ □ mumps age: _____ □ rubella age: _____

□ whooping cough age: _____ □ measles age: _______ □ other(s): ___________________

We are here to serve you and your family and We encourage you to ask questions. Your participation is vital and will help ensure your child's chiropractic success.

Authorization for care of minor

I hereby authorize helping hands chiropractic, dr. Williams, and staff to administer chiropractic care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees at the time services are rendered.

Name of parent/guardian: ____________________________________ date: ___________________

Signature of parent/guardian: ____