ChiropracticWorks
A Healthy Body for a Healthy Life

Confidential Pediatric Information

Date _____

Personal Information

First Name: _____ Last Name: _____ Middle Initial: _____

Parents Name(s): _____

Address: _____

City / State / Zip _____

Home Phone: ( )_____ Mobile Phone: ( )_____

E-mail: _____

Childs Social Security #: _____ Birthdate: _____ Age: _____ Sex: ○ M ○ F

Emergency Contact

Name:_____ Relation: _____

Home Phone: ( )_____ Work Phone: ( )_____

Address: _____

_____

Health Information

Insurance Company: _____

Phone #_____ Address: _____

Insured's Name_____ Insured's SS#_____ Group # _____

Insured's Birth Date:_____Insured's Employer: _____

Health Information

Purpose for contacting us: _____

Have you seen other Doctors for this condition: ○ Yes ○ No

Ifyes, please list other doctors' names and prior treatments: _____

_____

Previous Chiropractor:_____

Date of last visit:_____ Reason: _____

Name of Pediatrician:_____

Date of last visit:_____ Reason: _____

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

Please list all the medications, including antibiotics, your child has taken during his/her lifetime: _____

Has your child ever had a reaction to any vaccination? ○ Yes ○ No

If yes, please list the vaccination and reaction: _____

_____

According to the National Safely 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

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 Please list:_____

Has your child ever been involved in a car accident? ○ Yes ○ No Please list:_____

Has your child ever been seen on an emergency basis? ○ Yes ○ No Please list:_____

Other traumas not described above? ○ Yes ○ No Please list:_____

Any prior surgery? ○ Yes ○ No Please list:_____

Prenatal History

Name of Midwife/Obstetrician:_____

Complications during pregnancy? ○ Yes ○ No Please list:_____

Ultrasounds during pregnancy? ○ Yes ○ No Number_____

Any medications during pregnancy? ○ Yes ○ No Please list:_____

Cigarette/alcohol use during pregnancy? ○ Yes ○ No

Location of birth: ○ Home ○ Birthing Center ○ Hospital

Birth Intervention: ○ Forceps ○ Vacuum Extraction ○ Ceasarian Section

If ceasarian section, was it an emergency or planned?_____

Complications during delivery? ○ Yes ○ No Please list:_____

Genetic disorders or disabilities? ○ Yes ○ No Please list:_____

Birthweight:_____ Birthlength:_____ APGAR scores:_____

Feeding Information

Breast fed: ○ Yes ○ No How long:_____

Formula fed: ○ Yes ○ No How long:_____

Introduced to solids at: _____ Months

Introduced to cow's milk at: _____ Months

Food/juice allergies or intolerance? ○ Yes ○ No Please list:_____

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

I, _____ being the parent or legal guardian of _____ have read and fully understand the terms of acceptance and hereby grant permission for my child to receive chiropractic care.