Pediatric History Form

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 and your family feel more comfortable. Many types of stressors (physical, mental, and chemical) can interfere with your child's growing brain, 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: ________________________________ Today's Date: _________________ Birth Date: _____/_____/______

Male / Female / Non-binary (Circle one) Weight: ________lbs. Height: _________ft._________in

Address: ____ City:____________________ State: ______________

Zip: _______________ . Phone #_________________________ Referred by: ______________________________________

Guardian(s) Name: ____ Relationship:________________________________

Reason for pursuing care: □maintenance □improved health □concern: ____

Family history: ____

____

Health Concern: List according to severity	Rate of severity: 0=No Pain, 10=Unbearable	When did Problem start?	Have you had this problem before? When?	Did Problem begin with an Injury?	Constant or Intermittent
1.				Y / N	C / I
2.				Y / N	C / I
3.				Y / N	C / I
4.				Y / N	C / I

Please Mark "**P**" For In The **Past** OR Mark "**C**" For **Currently** Have:

___ Headaches ___Ear Infection ___Sinus Issues ___Kidney Problems ___Epilepsy /convulsions ___Bed Wetting
___Hearing loss ___Frequent Colds ___Bladder Problems ___Sleep Problems ___Diabetes ___Constipation
___Jaw/ TMJ pain ___Ringing in Ears ___Thyroid Issues ___Seizures ___Tight/Sore Muscles ___Diarrhea
___Neck Pain ___Dizziness ___Asthma ___Scoliosis ___Sports Injury ___Digestive Issues
___Shoulder pain ___Loss of Energy ___Chest Pain ___Infertility ___ Difficulty Breathing ___Allergies
___Arm Pain ___Nervousness ___Heart Problems ___Fibromyalgia ___Double/Burry Vision ___Depression
___Upper back pain ___Joint Pain ___Nausea ___Migraines ___GERD/Gastric Reflux ___Loss of Balance
___Mid Back Pain ___Anxiety ___Ulcers ___Tremors ___Numb/tingling in arms/hands ___ADD/ADHD
___Sciatica ___ Disc Problems ___ Scoliosis ___ Growing pains ___ Numb/Tingling in Legs/Feet ___ Poor Posture
___ Skin Problems ___ Foot Pain ___ Knee Pain ___ Lower Back Pain ___ Stomach Problems ___ Hip/Leg Pain
___Colic ___Fainting ___Anemia ___Poor Appetite ___Orthopedic Problems ___Hypertension
___Ruptures/Hernia ___Behavioral Problems

Other: ____

Medical History

How did the primary concern begin: □ Unknown □ Gradual □ Sudden

Any bowel or bladder problems since this problem began? □No □Yes If yes, describe:______________________________

____

How is the problem now?

□ Rapidly Improving □ Improving Slowly □ About the Same □ Gradually worsening □ On and Off

Have you ever seen other doctors for the primary concerns? □ Yes □ No

If Yes: □ Chiropractor □ Medical doctor □ Other____

Who?____________________________ When?____________________________ Results?_________________________________

____

Name of Pediatrician: ___________________________________ City/State:___________________Last visit: ___/___/___

Reason for visit: ____

Present prescription drugs/ dosage? ____

Past prescription drugs/ dosage? ____

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

# of Doses of antibiotics your child has taken: Past 6 months __________ Total lifetime __________

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: ____

Other traumas not described above (bike wipeout, trampoline injury, etc.)?

____

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

Has you child Sustained an injury playing organized sports □ Yes □ No IF Yes, describe: ___________________________

____

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

____

Has your child ever sustained an injury in an Auto Accident: □ Yes □ No IF yes, describe; _________________________

____

List all surgical operations & years: ____

Has your child ever been knocked unconscious? □ Yes □ No Fractured A Bone? □ Yes □ No

Child's Name ______________________________________ Date: ___________________________

If yes to either of the above, please describe:____

____

Child's Name ____ Date: ____________________________

Prenatal History (Circle what applies)

Name of Obstetrician/Midwife: ____

Complications during pregnancy/delivery? Y/N Explain: ______________________________

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 Birthing Center Home

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

If Caesarian Section, was it (circle one): Emergency Planned

Genetic disorders/disabilities? Y/N List: ____

Birth Weight: _______________ Birth Length: _____________APGAR Scores: _____-_____

Feeding History

Breast Fed: Y/N How long? ___________ Formula Fed: Y/N How long? ________ Type: ________

Introduced to: Solid Foods @________ months Cow's milk @ ______ months

Food/ Juice allergies or intolerances: Y/ N List: _____________________________________

Lifestyle (please check all that apply):

Does your child: □eat healthy food (organic products, etc.) □drink water

□take probiotics □take vitamins Type: ____

Exercise: □none □mild □moderate □heavy □daily

Hobbies/ interests: ____

____

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

____

____

Developmental History (to the best of your knowledge)

Your child's spine is vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). Spinal nerve interference can affect the following.

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

Child's Name ____ Date: ____________________________

Activities Of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY:	EFFECT:			
Holding Head Up	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Tummy Time	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Nursing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting Up	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Crawling	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Standing Alone	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking Alone	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _______________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _______________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
Example: Crawling all around	Not crawling hardly at all	They used to be able to crawl no problem

____ Date: ____________________

Parent/Guardian Name

____

Signature

____ Date: ____________________

Doctor's Signature

Child's Name ____ Date: ____________________________

CONSENT TO TREAT A MINOR

Patient Name: ___________________________________ Date of Birth: ____________________

*Note: if you have more than one child, you may request a form in the office to include all your children

I,____, parent or legal guardian of the above named child(ren), give the following adults permission to make decisions regarding the necessary and/or routine treatment of my child(ren) including, but not limited to, diagnostic assessments, x-rays, medical records, billing, and chiropractic adjustments. I also authorize the discussion of confidential information regarding my child(ren) with the below authorized caregiver.

Authorized Caregivers:

Name: ___________________________ Relationship to patient: ________________ Phone: ____________

Name: ___________________________ Relationship to patient: ________________ Phone: ____________

Name: ___________________________ Relationship to patient: ________________ Phone: ____________

______________ (Parent/Guardian Initials) *I understand that any person binging my child(ren) in for treatment not listed above must have a letter of consent from me or treatment may be delayed or refused. This authorization will remain in effect until information for consent is provided or otherwise denied. If any person on the above list changes, it is my responsibility to contact Inspire Life Chiropractic and sign an updated consent form.*

Parent/Guardian Signature:____ Date:__________________

Inspire Life Representative: ____ Date: _________________

(Optional) We love to have kid's pictures in our office! If you would allow us to have your child's picture in the office, please sign below.

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Inspire Life Chiropractic, or anyone authorized by Inspire Life Chiropractic, of any and all photographs/videos which were taken of my child, for the purposed of promotional TV, website, social media and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute the property of Inspire Life Chiropractic, solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentially, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Inspire Life Chiropractic to share this information via their website and their Facebook/social media including Twitter and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws).

Signature: ____ Date: ______________________

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF THE X-RAYS IN OUR FILES.

PLEASE NOTE: IF X-RAYS ARE NECESSARY, THEY ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF INSPIRE LIFE CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

IF YOUR CHILD IS AN INFANT OR UNDER THE AGE OF FIVE, IT IS UNLIKELY THEY WILL NEED CHIROPRACTIC POSTURAL XRAYS. HOWEVER, PLEASE SIGN BELOW FOR FUTURE REFERENCE.

BY SIGNING BELOW, YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS

CHILDS NAME ____ CHILDS AGE ____________

PARENT/GARDIAN SIGNATURE_____________________________________ DATE ___________

DO NOT WRITE BELOW THIS LINE -- DO NOT WRITE BELOW THIS LINE -- DO NOT WRITE BELOW THIS LINE