Amato
chiropractic wellness center
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Chiropractic Registration and History – Pediatric Form

Child's Name: _____ S. S. #: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Birth Date: _____

Mailing Address: _____

Names of Parents/Guardians: _____

Home Phone: _____ Parent Cell: _____ Parent Work: _____

Parent Email: _____

***Whom may we thank for referring you?* _____**

Health History

Reason for visit? _____

Have you received other types of care for your child's condition? (Chiropractic, Pediatrician, Medication, Other)

Please name other Doctors that have cared for your child:

Date of last Spinal Examination? (X-Ray?) _____

Number of Doses of <u>Antibiotics</u> your child has taken:

During the past Six Months: _____, Total during child's lifetime: _____

Number of Doses of <u>Other Prescription Medications</u> your child has taken:

During the past Six Months: _____, Total during child's lifetime: _____

Please *circle* any current condition your child may have and *check* any conditions your child has had in the past.

ADD/ADHD	Abnormal gait/limping	Abnormal stools	Autism
Aspergers	Asymmetry at hip	Asthma/Allergies	Back pain
Balance Issues	Bed Wetting	Behavioral Issues	Constipation
Colic	Convulsions	Colds/Flu	Constant Crying
Diarrhea	Depression	Digestive Issues	Difficulties with sleep
Ear Aches	Ear Infections	Easily Fatigued	Extremity Pain
Fainting Spells	Food Allergies	Growing Pains	Headaches
Inability to tolerate exercise		Nose Bleeds	Pain w/ bowel movement
Pain w/ exercise	Recurring Fevers	Scoliosis	Seizures
Stomach Pain	Temper Tantrums	Unusual smelling urine	
Vomiting	Other	Other	

For infants under 2 yrs of age, please *circle* if they have had the following:

Breast Milk	Cows Milk	Soy Milk	Goats Milk
Rice Milk	Oat Milk	Formula	Formula (Soy based)
Fruits or Fruit Juice	Medications	Sweets	Solids
Organic Foods	Vegetables/Vegetable Juice	Vitamins	Other

Vaccination History:

Mother's Health During Pregnancy

Please *circle* if applicable to mother during pregnancy.

Alcohol Use	Allergies	Antibiotics	Bleeding
Back Pain	Caffeine	Chiropractic Care	Complications
Diagnosed Illness	Gestational Diabetes	Hospitalization	Immunizations
Medications	Physical Injury	Pre-eclampsia (high blood pressure)	
Premature Labor	Prenatal Classes	Prenatal Care	Severe Bloating
Vitamins/Supplements		Weight Lose	

Please *circle* if applicable to your Labor and Delivery.

Caesarian	Complications	Homebirth	Induced Labor
Epidural	Longer than 12 hrs	Longer than 20 hrs	Premature Delivery
Use of Forceps	Use of Fetal Monitor	Use of Vacuum	Vaginal Birth

Injuries/Surgeries

Falls: _____

Broken Bones/Dislocations: _____

Surgeries: _____

Medications/Vitamins

Current Medications: _____

Vitamins: _____

Supplements: _____

Trauma History

Has your child ever been involved in a car accident? _____ No _____ Yes

If so, please list: _____

Is/Has your child been involved in any high impact or contact type sports (Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.) _____ No _____ Yes

If so, please list: _____

Please list any slips, strains, falls your child may have had:

What are your ultimate goals for your child in receiving Chiropractic Care?

I hereby authorize this office and its Doctors to perform any necessary care/procedures, including X-rays, to fully evaluate my child's condition. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Insurance Company: _____ Policy #: _____

Signed: _____ Date: _____

Witness: _____