URBAN HEALTH GROUP

Pediatric Chiropractic 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 and 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.

Name: _____ Date:_____

Parents/Guardians: _____

Address:_____Postal Code:_____

Home#_____Cell#_____

Work# _____Email address: _____

Date of Birth: _____ Sex: M/F Weight: _____Height: _____

Who may we thank for referring you to our office?_____

Health History: Many Childhood illnesses can be due to misaligned vertebrae and pinched nerves in the spine.

What is your purpose for contacting us? _____

Other Doctors seen for this condition and course of treatment: _____

_____

Many childhood illnesses can be due to misaligned vertebrae and pinched nerves in the spine. Has your child suffered from any of the following in the past six months?

__Ear Infections	__Dizzy/Clumsy	__Seizures	__Recurring fevers	__Headaches
__Tonsillitis	__Scoliosis	__ADHD	__Temper Tantrums	__Growing Pains
__Asthma/ Allergies	__Digestive problems	__Learning Difficulties	__Scoliosis	__Back Problems
__Colic	__Bed Wetting	__Chronic Colds	__Sleeping Difficulties	__Other _____

Previous Chiropractor: _____

Date of last visit: _____ Reason: _____

Paediatrician: _____

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Date of last visit: _____ Reason: _____

Number of doses of antibiotics your child has taken in past 6 months: _____

In lifetime: _____

Number of doses of prescription medications your child has taken in past 6 months___

In lifetime: _____

List: _____

VaccinationHistory: _____

Family History of Disease/Illness _____

Prenatal History: Often, birth trauma can produce some of the first spinal problems in the delicate spine of a newborn.

Name of Midwife or Obstetrician: _____

Did you have any complications during your pregnancy? Y/N Explain:_____

Did you have ultrasounds during pregnancy: Y/N Number_____

Did you smoke or consume alcohol during your pregnancy: Y/N

Were any of the following interventions used in your delivery (circle)?

Forceps Vacuum Extraction Induced Epidural C-section-planned or emergency Other: _____

Were there any complications during your delivery? Y/N

Explain: _____

Birth Weight: _____ Birth Length: _____

APGAR at birth: _____ at 5minutes_____

Feeding History:

Was your child breastfed? Y/N For how long? _____

Was your child formula fed? Y/N For how long?_____ Type: _____

When did you first introduce solids? _____months. When did you introduce cow's milk? _____ months.

Does your child have any food or juice allergies/intolerances? _____

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Developmental History: Many childhood falls can produce long-term spinal misalignments that may surface many years later in life.

Has your child ever fallen from a change table, tree, bicycle, cirb, stair or other height? Explain:_____

_____

Has your child ever been in a car accident? Y/N

Explain: _____

Has your child ever had a sports injury or been involved in a high impact or contact sport (soccer, football, hockey, gymnastics, cheerleading, martial arts)? Y/N

Explain: _____

Has your child ever had surgery or been seen on an emergency basis?_____

Menarche: Y/N Age: _____

We are here to serve you and encourage you to ask questions. Your participation in your family's care is vital and will help determine your child's results.

Authorization for care of a minor:

I, _____(please print name of parent/guardian), hereby authorize this office and it's 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 fees charged by this office.

Signed: _____ Witnessed: _____ Date: _____