Welcome to Advantage Chiropractic Clinic
Pediatric Health 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. 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:_____ Preferred Name: _____

Address:_____ City:_____ State:_____Zip:_____

Home Phone: (_____)_____ Cell: (____)_____ Weight _____ Height _____

Date of Birth: _____ S.S.#:_____-_____-_____ Gender: ____Female ____Male

Parent(s)/Guardian Name(s): _____

Referred By:_____ How Did You Find Us? _____

Purpose for Contacting Advantage Chiropractic ? (Wellness, Injury, Illness or Other)

_____

_____

Have Other Doctors Been Seen for this Condition? ☐ Yes ☐ No If Yes, List Doctor Name(s) and Prior Treatments:

_____

Was child's birth a difficult delivery ? _____

Do you have any dietary issues or nutritional concerns? _____

How would you describe your child's activity/energy level? ☐ Lethargic ☐ Inactive ☐ Normal

☐ Over Active ☐ Hyperactive ☐ Other

Has this level changed recently?_____

Any Other Health Problems? _____

_____

Check Any of the Following Conditions Your Child Has Experienced During the Past Six Months:

☐ ADD/ADHD	☐ Allergies	☐ Asthma / Colic	☐ Autism	☐ Bed Wetting
☐ Car Accident	☐ Chronic Colds	☐ Digestive Problems	☐ Ear Infections	☐ Growing / Back Pains
☐ Headaches	☐ Recurring Fevers	☐ Scoliosis	☐ Seizures	

☐ Other:_____

Significant Family History _____

_____

Previous Chiropractor (If Any):_____

Date of Last Visit:_____ Reason:_____

Were you satisfied with the care your child has received there? ____Yes ____No

Name of Pediatrician:_____

Date of Last Visit:_____ Reason:_____

According to the National Safety Council, approximately 50% of children fall head-first from a high place during their first year of life (for example: a bed, changing table, stairs, etc.).

Has your child had a head-first fall? ____ Yes ____ No

Is/has your child been involved in any high impact or contact sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? ____ Yes ____ No

List:_____

_____

Has Your Child Ever Been Involved in a Car Accident? ____ Yes ____ No

List:_____

Has Your Child Been Seen on an Emergency Basis? ____ Yes ____ No

List:_____

Other Traumas Not Described Above? ____ Yes ____ No

List:_____

Prior Surgery? ____ Yes ____ No

List:_____

Is There Anything That You Would Like Us To Know About Your Child?

_____

_____

_____

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