Welcome to Advantage Chiropractic Clinic
Pediatric Health Form (Age 0 - 12 years)

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 below. We look forward to working with you to create better health for your family.

(Please Print)
Patient Name: ______________________________________ Preferred Name: ______________________

Address:____

City:________________ State:_______ Zip:__________ Cell: (_____)________________

Weight ___________ Height ___________ Date of Birth: ________________

S.S.#:_________-______-________ Gender: ____Female ____Male

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

Insurance Company Name___________________ Policy # ________________ Group # _____________

How Did You Find Us? ____

What is your reason for contacting Advantage Chiropractic Clinic? (Wellness, Injury, Illness, or Other)

____

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

____

____

Describe Labor/Delivery (mark all that apply)\

____ Spontaneous Labor ___ Labor Induced ____ C-Section Delivery
___ Labor was Doctor Assisted ____ Forceps/Vacuum Extraction ____ Premature Delivery

Birth Trauma (mark all that apply)

___ Long Birth ___ Stuck in Birth Canal ___ Odd Shaped Head ___ Respiratory Distress
___ Cord Around Neck ___ Lack of Use of One Arm ___ Head Rotated to One Side ___ Bruising

How would you describe your child's activity/energy level?

___ Lethargic ___ Inactive ___ Normal ___ Over Active ___ Hyperactive ___ Other

Has this level changed recently? Yes ____ No ____

Pediatric Health Form (Age 0 – 12 years)

Any significant family health history?____

____

Medications / Supplements? ____

Check any of the following conditions your child has experienced or is diagnosed with:

____Constipation ____Diarrhea ____ ADHD ____ ADD ____ Autism ____ Sensory Issues ____ Asthma

____ Learning Difficulties ____ Ear Infections ____ Vertigo ____ Chronic Fatigue ____ Sinus Issues

____ Scoliosis ____Growing Pains ____Headaches ____Back Pain ____Neck Pain _____ Bed Wetting

____ Night Terrors ____Convulsions ____Epilepsy ____Balance/Coordination Issues

____ Concentration Issues ____Behavioral Problems

Are there any other health problems we should be aware of?

____

____

Previous Chiropractor (If any):____

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

Details: ____

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: ____