MILADIN CHIROPRACTIC, INC

PEDIATRIC HISTORY FORM (AGE 0-12)

First Name: _________________________ Initial: ____________ Last: ______________________________

Social Security #: _______________________ Address: ________________________ City: _________________________

State: _____________ Zip: ___________________

Birth Date: _____/_____/_____ Sex: ☐F ☐M

Weight: ____________ Height: ____________

Name of Parental Contact: ____

Phone: _______________________________

Referred By: ____

Check Any of the Following Conditions Your Child has suffered from during the <u>PAST SIX MONTHS</u>:

☐ **Ear Infections** ☐ **Scoliosis** ☐ **Seizures** ☐ **Chronic Colds** ☐ **Headaches**

☐ **Asthma/ Allergies** ☐ **Digestive Issues** ☐ **ADHD** ☐ **Recurring Fevers** ☐ **Growing Back Pain**

☐**Colic** ☐ **Bed Wetting** ☐ **Car Accident** ☐ **Temper Tantrums** ☐ **Other**

Family Health History: ____

Delivery:

Birth: ☐ Vaginal at Home ☐ Vaginal w/ Epidural ☐ Vaginal w/o Epidural ☐ C Section

Were Forceps used in the delivery process? ☐ N ☐ Y

Was Vacuum extraction used in delivery process?☐ N ☐ Y

MILADIN CHIROPRACTIC
Dr. Craig J. Miladin DC
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East Liverpool OH 43920
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330-382-7353 fax

AUTHORIZATION FOR CARE OF MINOR (UNDER 18 YEARS)

I hereby authorize this office and its doctors to administer care to my daughter/son as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Minor (print name) ________________________________

Date of Birth ______________

Parent/ Guarantor (print name) _______________________________

Signature of Parent/ Guarantor ________________________________

Date _______________