Balanced spine center

PT ID:_____ INS:_____
NPE:_____ Ref:_____

PEDIATRIC HEALTH FORM

Today's Date: _____/_____ /_____ SSN#: _____

Patient's Name: _____

Nickname: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: ○M or ○F

Parent / Guardian Name: _____

1st Contact Phone#: _____ 2nd Contact Phone#: _____

Parent's E-mail: _____

Address: _____

City: _____ State: _____ Zip Code: _____

How did you hear about this office? _____

Has he/she had previous Chiropractic Care? ○YES or ○NO

Doctor's Name: _____ Last Date of Visit: _____

Please check the reasons you are pursuing Chiropractic Care for your Child:

- ☐ He/she is continuing ongoing care from another chiropractor
- ☐ I recently had my spine checked and I see the value in getting my child checked
- ☐ I'm concerned about his/her health and I'm looking for answers
- ☐ I want to improve my child's immune function
- ☐ I have no idea why we are here. Please take the time to explain to me what you do for children
- ☐ He/she has a specific condition that concerns me:
  Explain condition/symptoms: _____

In order for us to better understand your child's current level of health, please check any of the following body signals, which your child has or has had previously:

- ☐ **ADD / ADHD**
- ☐ **Allergies**
- ☐ **Asthma**
- ☐ **Bedwetting**
- ☐ **Car Accident**
- ☐ **Colic**
- ☐ **Digestive Problems**
- ☐ **Ear Infection**
- ☐ **Other:** _____
  _____
- ☐ **Frequent Colds / Flu**
- ☐ **Growing / Back Pain**
- ☐ **Headaches**
- ☐ **PDD / Autism**
- ☐ **Postural Imbalance**
- ☐ **Scoliosis**
- ☐ **Seizures**
- ☐ **Sinus Problems**

Please list prescriptions or over-the-counter medications your child is taking: _____
_____

Known Allergies: _____

Number of does of antibiotics you child has taken during the past 6 months: _____
Total during lifetime: _____
List reasons for taking them: _____

Number of doses of other prescriptions medications taken during the past 6 months: _____
Total during lifetime: _____
List medications: _____

Prenatal History:
Adopted? .....○YES or○NO
Complications during pregnancy? .....○YES or○NO
If yes, please explain: _____
Ultrasounds during pregnancy? .....○YES or○NO
If yes, how many: _____
Medications/drugs/caffeine during pregnancy? .....○YES or○NO
If yes, please list: _____
Cigarette/alcohol use during pregnancy? .....○YES or○NO
Complications during delivery? .....○YES or○NO
If yes, please list: _____
Genetic disorders or disabilities? .....○YES or○NO
If yes, please list: _____
Food allergies or intolerances? .....○YES or○NO
If yes, please list: _____

Location of birth: ☐ Hospital ☐ Birthing Center ☐ Home
Birth Intervention: ☐ Mother Induced ☐ Mother medicated (Pitocin,etc) ☐ Forceps
☐ Vacuum Extracted ☐ Baby given medication after delivery
Type: _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (i.e. a bed, changing table, down the stairs, etc). Was this the case with your child? .....○YES or○NO
If yes, please list: _____

Is/Has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, hockey, baseball, cheerleading, martial arts, etc)? .....○YES or○NO
If yes, please list: _____

Has your child been seen on an Emergency basis? .....○YES or○NO
If yes, please list: _____

Any prior surgery? .....○YES or○NO
If yes, please list: _____

PATIENTS WHO DO NOT CONTACT THE OFFICE TO CANCEL OR RESCHEDULE THEIR NEW PATIENT APPOINTMENT (NEW PATIENT EXAM OR REPORT OF FINDINGS) 24 HOURS PRIOR TO THEIR APPOINTMENT TIME WILL BE CHARGED A $25.00 FEE. _____ PATIENT INITIAL

_____ _____
Parent / Guardian Signature **Date**