CONTINUUM CHIROPRACTIC PEDIATRIC HEALTH HISTORY FORM

Today's Date______________________

ABOUT THE CHILD

Name ____ Age ______ Date of Birth ______________________________

Gender ❑ M ❑ F Height _____________________ Weight ___________________________

Home Address ____________________________________City __________________ State ______ Zip ____________

Names and Ages of Siblings____

Parent A	Parent B
Name ____	Name ____
Cell phone (________) _________________________	Cell phone (________) _________________________
Home phone (________) _________________________	Home phone (________) _________________________
Employer ______________________________________	Employer ______________________________________
E-mail ____	E-mail ____

How did you hear about our office? ____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Continuum Chiropractic can address for your child? _________________________________

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Please describe how these concerns are affecting your child's quality of life. _________________________________

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EXPECTATIONS OF CARE

I would like my child to experience the following benefits from Chiropractic Care:

Check all that apply

- ❑ Symptomatic relief of pain or discomfort
- ❑ Correction of the cause of the problem as well as relief of symptoms
- ❑ Prevention of future problems
- ❑ Healthier spine and nerve system
- ❑ Optimal health on all levels
- ❑ OTHER____

HEALTH, WELLNESS, AND CHIROPRACTIC CARE

PREGNANCY & BIRTH

During pregnancy, did the mother:
❑ Experience any significant illnesses, difficulties, or trauma? ____
❑ Take any drugs/medications? ____
❑ Smoke or consume alcohol

Where and how was the child delivered (check all that apply):
❑ Home birth ❑ Hospital birth ❑ Birthing Center ❑ Vaginal ❑ Water birth ❑ Caesarean

Was the delivery premature? ❑ No ❑ Yes Weeks ______________________________Weight __________________
Approximately how long did labor last? _________________ hours
Was labor artificially induced? ❑ No ❑ Yes ____
Was it determined that the child was breech or otherwise malpositioned? ❑ No ❑ Yes ___________________________

The birth process can be traumatic to a baby's spine and cause interference to the nervous system. Please check which, if any, of the following were administered during labor and birth.

❑ Epidural ❑ Forceps ❑ Vacuum ❑ Medications ____________________
❑ Pitocin ❑ Episiotomy ❑ Manual traction of the neck ____________________

Please check all that apply to the baby's status immediately after birth:

❑ Jaundice ❑ Respiratory problems ❑ Broken bones _____________________________________
❑ Feeding problem ❑ Displaced joints ❑ Other conditions ____________________________________

APGAR Score _________________________

INFANCY & CHILDHOOD

Was your child breastfed? ❑ No ❑ Yes For how long? ____

At what age was food (other than breast milk or formula) first introduced? ______________________________________
What were the first 3-5 foods given to the child?____
____

Are there any known food allergies? ____

Have you chosen to vaccinate your child? ❑ No ❑ Yes.
If yes, did you follow the traditional schedule for all vaccines? ❑ No ❑ Yes.

Did your child have any negative reactions to any vaccines? ❑ No ❑ Yes.
If yes, please explain? ____
____

Please check all that apply and give any necessary details:
- ❑ Child exposed to second hand smoke.
- ❑ Has taken antibiotics. Explain ____________________
- ❑ Currently taking medication. Explain ____________________
- ❑ Currently taking supplements. Explain ____________________
- ❑ Has allergies. Explain ____________________

  What treatments have you used? ____________________

Is the reason you are seeking care related to?: ❑ Auto Accident ❑ Fall ❑ Chronic ❑ Home Injury ❑ Other

Please check all that apply to your child and give any necessary details:

- ❑ Uncoordinated/Accident prone
- ❑ Has been hospitalized. ____________________
- ❑ Had a severe trauma. ____________________
- ❑ Been in an automobile accident. ____________________
- ❑ Has fractured a bone or dislocated a joint. ____________________
- ❑ Has/had a chronic illness. ____________________
- ❑ Has had surgery. ____________________

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? ❑ Y ❑ N Name of D.C. ____________________

Reason ____________________ How long? ____________ Date of last visit ____________

Why was care stopped? ____________________

Do you have a regular pediatrician? ❑ Y ❑ N Name: ____________________

When was the last visit? ____________ Reason: ____________________

Are you satisfied with your care there? ❑ Y ❑ N

Have you consulted or do you regularly consult any of the following health care providers for your child?

Check all that apply ❑ Massage Therapist ❑ Naturopath ❑ Acupuncturist ❑ Homeopath ❑ Mental Health Professional ❑ Occupational or Physical Therapist ❑ Other

Reason ____________________

____

____

HEALTH HISTORY

Indicate C for current and P for past

____ Allergies
____ Asthma
____ Colic
____ Constipation
____ Feeding Difficulty
____ Ear Infections
____ Bed wetting
____ Headaches
____ Respiratory disorder
____ Joint pain
____ Diabetes
____ Eczema
____ Cold/Flu
____ Digestive issues
____ Bathroom difficulty
____ Learning disability
____ Difficulty sleeping
____ Behavioral problems

Details:____

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DEVELOPMENTAL HISTORY

At what age did your child achieve the following milestones?:

Hold head up ________
Sit unassisted ________
Crawl ________
Stand ________
Walk unassisted ________
Talk ________

Did your child have any difficulty reaching any of these milestones? ______________________________

____

IMPORTANT:

Is there anything not mentioned on this form that you feel is important for us to know about your child's heath?

____

____

____

____

What activities and/or sports does your child enjoy? ____

____

What is your child's favorite subject in school? ____

What is your child's favorite book? ____

What are your child's 3 favorite foods? ____

Financial Information

Payment in full is expected on all FIRST VISIT services (whether you have insurance coverage or not.) All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit/Debit Card

Is this an Auto Accident Related Injury? ❑ Yes ❑ No

If **yes**, please provide us with the following information:

Has your child been treated elsewhere? ❑ Yes ❑ No

If **yes**, where? ❑ Emergency Room ❑ Primary Care ❑ Other ______________________________

What services were provided? ❑ MRI ❑X-Rays ❑ Medication ❑ Therapy

❑ Other (details)____

PLEASE READ AND SIGN

The information I have provided on this case history form is true and accurate to the best of my knowledge. I give Dr. Hayes Modlin and Dr. Thad Modlin permission to render care to my child today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Child's Name: (Printed) ____

Parent or Legal Guardian's Name:

(Printed)____

Signature ____ Date: ____________________

Thank you for choosing Continuum Chiropractic.

We look forward to helping you.