Name_________________________________ Age___ DOB___/___/____ Sex___ Ht_____ Wt_____
(First) (Middle) (Last)

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

Address_______________________ City_______________ State_____ Zip__________

Home Phone_______________________ Who referred you to our office?______________

PEDIATRIC CHIROPRACTIC CASE HISTORY

Purpose for contacting our office:____

Other doctors seen for this condition:____________________________________

Other health problems:____

Check any of the following conditions your child has suffered from:

☐ ADHD	☐ Allergies/Rashes	☐ Asthma	☐ Auto Accident
☐ Bed Wetting	☐ Chronic Colds	☐ Colic	☐ Digestive Problems
☐ Ear Infections	☐ Headaches	☐ Nose Bleeds	☐ Recurring Fevers
☐ Scoliosis	☐ Seizures	☐ Other____________	

Previous Chiropractor:_________________________ Date of last visit:______________

Name of Pediatrician:__________________________ Date of last visit:______________

Number of doses of antibiotics your child has taken:

During the past six months:______________ During entire life:______________

Number of doses of medications your child has taken:

During the past six months:______________ During entire life:______________

Vaccination history:____

Complications during pregnancy: ☐ No ☐ Yes, explain__________________________

Medication during pregnancy: ☐ No ☐ Yes, how many__________________________

Alcohol/Cigarette use: ☐ No ☐ Yes, explain__________________________

Location of delivery: ☐ Hospital ☐ Home ☐ Other__________________________

Complications during delivery: ☐ No ☐ Yes, explain__________________________

Birth Intervention: ☐ Cesarean Section ☐ Vacuum Extraction ☐ Spinal Tap ☐ Forceps

Birth Height:________________ Birth Weight:__________________ APGAR Scores:__________________

Breast Fed: ☐ No ☐ Yes, how long______________ Formula: ☐ No ☐ Yes, how long________________

Introduced to solids at____________ months. Cow's milk at ___________ months.

Childhood Disease:

☐ Chicken Pox, age_______ ☐ Rubeola, age_______ ☐ Whooping Cough, age_________

☐ Rubella, age_______ ☐ Mumps, age_______ ☐ Other_________, age_________

At what age was your child able to:

Respond to sound stimuli_________ Hold head up________ Stand alone____________

Respond to visual stimuli_________ Cross Crawl_________ Walk alone____________

Check all surgeries or procedures that apply: ☐ My child has never had any surgeries or procedures

☐ Vaccinations ☐ Tonsillectomy ☐ Hernia ☐ Other_____________________________

List any medications your child is currently using and reason for use_______________________________

____

Please provide any other relevant, health-related information______________________________________

____

CONSENT TO X-RAY- Only if the Doctor recommends it for your child

By my signature below I am acknowledging that I have had the opportunity to discuss any risks associated with exposure to x-rays for my child. After consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my child's case. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

Signature________________________ Date___________

Do you have Health Insurance? ☐ No ☐ Yes (same as parent under chiropractic care)

☐ Yes (parent not under care, please fill out the box bellow)

Name of Insured________________________________ DOB____/____/____ SSN_____-_____-_______

Insured's Employer______________________________ Insured's Phone Number__________________

Insurance Company______________________________ Policy Number_________________________

I have read the above information and certified it to be true and correct to the best of my knowledge, and hereby authorize PROHealth Chiropractic Center to provide my child with chiropractic care, in accordance with Connecticut's statutes.

Parent / Guardian Signature____ Date__________________