Pediatric History Form

LIMITLESS CHIROPRACTIC

Understanding the Importance of Chiropractic Care: *You were born to be healthy all of your life. Good health depends upon everything in your body being connected to your brain by nerves that pass between the bones of your spine. A subluxation is a disconnection between your brain and body affecting your health. Chiropractic restores this connection.*

About the Patient

Child's Name:_____ Age:_____ Today's Date:_____

DOB:____/____/_____ **At birth:** Height: _____ Weight: _____ Weeks gestation:_____ Labor hrs: _____

Gender: ☐ M ☐ F Phone (Home):_____ Current Height:_____ Current Weight: _____

Address:_____ City:_____ State:_____ Zip: _____

Email:_____ Referred by:_____

Mother's Name:_____ DOB:_____ Mother's Mobile:_____

Father's Name: _____ DOB: _____ Father's Mobile: _____

Pediatrician/Family MD: _____ Last Visit:_____

Reason for Visit:_____ Any previous chiropractic care? ☐ Yes ☐ No

Who is responsible for this bill?_____ Vaccinations: ☐ Yes ☐ No ☐ Delayed

Please list any medications: _____

Present Complaints

Reason for seeking care: ☐ Wellness Check-up ☐ Injury or Accident ☐ Other_____

Please explain: _____

If your child is experiencing *Pain/Discomfort* please identify where:_____

When did the Problem first begin? Date: ___/___/_____ ☐ Unknown

This problem come on: ☐ Gradually ☐ Suddenly

Ever had this problem before? ☐ No ☐ Yes If yes, when? _____

Any bowel or bladder problems since this problem began?: ☐ No ☐Yes

If yes, describe: _____

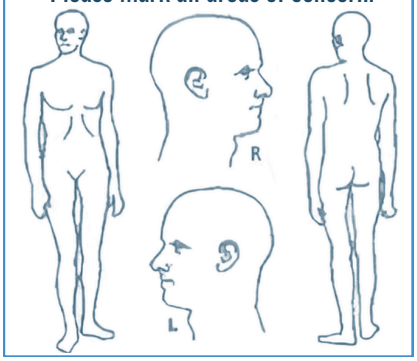
Have you seen any other doctors for this problem? ☐ No ☐ Yes

If yes, who and when? _____

What were the results of past treatment? _____

_____

Please mark all areas of concern.



How is this problem NOW?: ☐ Rapidly Improving ☐ Improving Slowly

☐ About the Same ☐ Gradually Worsening ☐ On & Off

Please list any medication taken for this problem:_____

Has your child ever sustained an injury playing organized sports? ☐ No ☐ Yes

If yes, please explain:_____

Has your child ever sustained an injury in an auto accident? ☐ No ☐ Yes

If yes; please explain:_____

Location of birth: ☐ Hospital ☐ Birthing Center ☐ Home OBGYN/Midwife: _____

Birth: ☐ Vaginal w/epidural ☐ Natural w/o epidural ☐ C-section

Were forceps or vacuum used? ☐ No ☐ Yes How long was labor process?_____

Feeding: ☐ Breast fed ☐ Formula

How was the pregnancy? (Complications, Ultrasounds, etc.): _____

_____

How was the child's birth process?: _____

_____

Family History

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other: _____

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other: _____

Is there any other family history you want us to know?_____

_____

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Child's Medical History

Has your child ever experienced any of the following? *Please check all that apply*:

- ☐ Headaches
- ☐ Orthopedic Problems
- ☐ Digestive Disorders
- ☐ Behavioral Problems
- ☐ Dizziness
- ☐ Neck Problems
- ☐ Poor Appetite
- ☐ ADD/ADHD
- ☐ Fainting
- ☐ Arm Problems
- ☐ Stomach Aches
- ☐ Ruptures/Hernia
- ☐ Seizures/Convulsions
- ☐ Leg Problems
- ☐ Reflux
- ☐ Muscle Pain
- ☐ Heart Trouble
- ☐ Joint Problems
- ☐ Constipation
- ☐ Growing Pains
- ☐ Chronic Earaches
- ☐ Backaches
- ☐ Diarrhea
- ☐ Asthma
- ☐ Sinus Trouble
- ☐ Poor Posture
- ☐ Hypertension
- ☐ Walking Trouble
- ☐ Scoliosis
- ☐ Anemia
- ☐ Colds/Flu
- ☐ Sleeping Problems
- ☐ Bed Wetting
- ☐ Colic
- ☐ Broken Bones
- ☐ Minor fall
- ☐ Major fall

During pregnancy:

- ☐ Recreational drug use
- ☐ Alcohol use
- ☐ Tobacco use

Additional Health Information

Does your child have any ongoing medical conditions not mentioned above? If yes, please describe: _____

_____

Allergies (please specify): _____

Other Medical Conditions or Concerns: _____

Any current medications or supplements? Please list: _____

_____

Authorization and Consent

I understand that I am directly and fully responsible to Limitless Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____

Parent or Legal Guardian's Signature Date

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