# Pediatric History Form

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there's any way we can make you and your family feel more comfortable. Many types of stressors (physical, mental and chemical) can interfere with your child's growing brain, spine and nervous system. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Whom may we thank for referring you to this office? _____ Today's Date: ____/____/_____
Child's Name: _____ Birth Date: ____-____-_____ Age: _____ ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip:_____

**Primary Guardian's Contact Information**

Guardian's Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Carrier: _____

E-mail Address: _____

Preferred Method of Contact: ☐ Email ☐ Home Phone ☐ Cell Phone

**Child's Health History**

Current Weight: _____ lbs. Current Height: _____ ft. _____ in.

Reason for pursuing care: □ Maintenance □ Improved Health □ Problem: _____

Check any of the following conditions that currently apply:

| | | | | |
|---|---|---|---|---|
| ☐ Ear infections | ☐ Scoliosis | ☐ Chronic Colds | ☐ Headaches | ☐ Allergies |
| ☐ Digestive problems | ☐ ADHD/ADD | ☐ Recurring Fevers | ☐ Colic | ☐ Growing pains |
| ☐ Bed wetting | ☐ Tantrums | ☐ Seizures | ☐ Asthma | ☐ Autism |
| ☐ Car accident (Please include when) | | ☐ Other: _____ | | |

Other doctors seen for this condition (Please include doctor's names and prior treatment):
_____

Previous Chiropractic Care? ☐ No ☐ Yes If yes, name doctor and last visit: _____

Name of Pediatrician and last visit: _____

Are you satisfied with the care your child has received at the pediatrician? ☐ No ☐ Yes

Number of Doses of antibiotics your child has taken: _____ Past 6 months: _____ Total lifetime: _____

Present prescription drugs/ dosage? _____

Past prescription drugs/ dosage? _____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.) _____

**Prenatal History**

Name of Obstetrician/ Midwife: _____

Location of birth: ☐ Hospital: _____ ☐ Birthing Center: _____ ☐ Home

Complications during pregnancy/ delivery ☐ No ☐ Yes If yes, explain: _____

Ultrasounds during pregnancy? ☐ No ☐ Yes If yes, how many: _____

Medications taken during pregnancy/ delivery? ☐ No ☐ Yes _____

Cigarette/ Alcohol use during pregnancy? ☐ No ☐ Yes If yes, how often: _____

Birth Intervention (Please check all that apply):
☐ Forceps ☐ Vacuum Extraction ☐ Caesarian Section

If Caesarian Section, was it: ☐ Emergency ☐ Planned

Genetic disorders/disabilities? ☐ No ☐ Yes: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____-_____

**Feeding History**

Breast Fed: ☐ No ☐ Yes How long: _____

Formula Fed: ☐ No ☐ Yes How long: _____ Type: _____

Introduced to: Solid Foods @ _____ months Cow's milk @ _____ months

Food/Juice allergies or intolerances: ☐ No ☐ Yes: _____

**Developmental History** (to the best of your knowledge)

Your child's spine is vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). Spinal nerve interference can affect the following. At what age was your child able to:
Respond to stimuli: _____ Cross Crawl: _____ Stand alone: _____ Respond to visual stimuli: _____ Hold head up: _____ Walk alone: _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs)

Did your child have a fall similar to what was described above? ☐ No ☐ Yes : _____

Have there been any other traumas? ☐ No ☐ Yes: _____

Has your child been involved in any sports? ☐ No ☐ Yes: _____

Has your child been seen by a physician on an emergency basis? ☐ No ☐ Yes: _____

Does your child: ☐ Eat healthy food (organic products, etc.) ☐ Drink water
☐ Take probiotics ☐ Take vitamins Type: _____
☐ Exercise: ☐ none ☐ mild ☐ moderate ☐ heavy ☐ daily

Hobbies/ interests: _____

Guardian name: _____ Signature: _____ Date: _____

We love to have kid's pictures in our office! If you would allow us to have your child's picture in the office, please sign below. For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Thrive Chiropractic llc., or anyone authorized by Thrive Chiropractic llc., of any and all photographs/videos which were taken of my child, for the purpose of promotional TV, website, social media and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute the property of Thrive Chiropractic llc., solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentially, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Thrive Chiropractic llc. to share this information via their website and their Facebook/social media including Twitter and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws).

Guardian name: _____ Signature: _____ Date: _____

# Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Thrive Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____

Child's Name Guardian's Name

_____ ___/___/_____ Witness Initials: _____

Guardian or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

*As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays from our files. Please note: If X-rays are necessary, in this office they are utilized to help locate and analyze vertebral subluxations. These x-rays are not to be used to investigate for medical pathology. The doctors of Thrive Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.*

If your child is an infant or under the age of 12, it is unlikely they will need chiropractic postural x-rays. However, please sign below for future reference.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ___/___/_____ Witness Initials: _____

Guardian or Authorized Person's Signature Date

**Females Only** → please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

_____ ___/___/_____ Witness Initials: _____

Guardian or Authorized Person's Signature Date