Pediatric Patient Information & History

We are pleased to welcome you to Advanced Spinal Fitness. Please take a few minutes to complete your child's health profile as completely as you can. If you have questions, we'll be glad to help you. We look forward to helping you and your family achieve maximum health through Chiropractic.

Name _____ Sex: ❒ M F Birth Date: _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____ Home Phone # (___) ____-_____

Parent's Work Phone or Cell # (___) ____-_____ Parent's E-mail _____

Name of M.D./D.O. _____ City _____ Phone # (___) ____-_____

Parent's Name(s) _____

This account is paid by You & : Primary Ins. ❒ Auto Ins. ❒ Other

Insurance Company _____ Contract # _____

Insured Parent's Soc. Sec. # _____-_____-_____ Insured Parent's Employer _____

Insured Parent's Birth Date _____

Whom may we thank for referring you to Advanced Spinal Fitness? _____

Reason for Visit

Your reason for this visit: ❒Specific Problem (s) Prevention Wellness / Maximize Health Potential

Please list your child's symptoms / complaints (if any): _____

_____

Please list other care undergone for this complaint, including medications: _____

_____

Has your child ever seen a Chiropractor? Yes No **If yes, when, and describe the experience**? _____

_____

Please check all that apply in regards to your child's Chief Complaint:

Date of Onset of Problem: ___/___/___ **Onset was**: Sudden Gradual Associated with an Event

Duration of Problem: _____ days / months / years **Pattern of Problem**: Constant Intermittent Occasional Cyclical

Is the problem getting: Worse Better Same **What makes the problem worse**?_____ **Better**?_____

Is the problem interfering with: School Hobbies Sports Family Sitting Standing Crawling Walking Eating Sleeping Concentrating Other_____

Please list any other health concerns, current or past: _____

Does your child have a family history of: Cancer Diabetes Heart Disease Stroke High Blood Pressure

Please complete the following sentences:

I have brought my child here because _____

My goal(s) for care is(are) _____

Health History & Health Habits

Birth History

Location: Home Birthing Center Hospital **Provider:** Midwife OB/GYN None **Duration of Gestation:** _____weeks

Please circle any that apply: Induction Forceps Vacuum Extraction C-Section **Duration of Birth:** _____

Medications given to mother during labor / delivery? Yes No **If yes, what?** _____

Describe any complications during or immediately after birth: _____

APGAR at Birth: _____ **After 5 Minutes:** _____ **Birth Weight:** _____ **Birth Length:** _____

Was your child alert and responsive within 12 hours after delivery? Yes No **If no, explain:** _____

Growth & Development

At what age did your child: Respond to Sound _____ Follow an Object_____ Hold up Head _____ Vocalize _____
Sit Alone _____ Crawl _____ Walk_____

Do sleeping patterns seem normal to you? Yes No **If no, explain:** _____

Number of bowel movements per day : _____ **Consistency of stools (firm, loose, normal):** _____

Chemical History

Was your child breast-fed? Yes No **How long?** _____ **Formula introduced at age** _____

Solid Food at age _____ **Any food / juice allergy or intolerance?** Yes No **If yes, what foods:** _____

During pregnancy did the mother smoke? Yes No **Drink alcohol?** Yes No **Use recreational drugs?** Yes No

Please list any illness of the mother during pregnancy: _____

Any drugs or supplements taken by the mother during pregnancy: _____

Any exposure to ultrasound? Yes No **If yes, how many and what was the medical reason?** _____

Any invasive procedures (amniocentesis, CVS)? Yes No **If yes, give reason:** _____

Any smokers living in the home? Yes No **Exposure to Fluoride (water, toothpaste)?** Yes No

Child's sugar consumption (soft drinks, candy, etc.) None Low Medium High

Has your child had any vaccinations? Yes No **If yes, any adverse vaccine reactions?** Yes No _____

Please list all drugs or supplements your child is currently taking: _____

Has your child ever taken antibiotics? Yes No **If yes, how many times?** _____

Social History

Circle if your child has had problems with any of the following: Breast Feeding Bonding Nightmares/Difficulty Sleeping
Making/Keeping Friends Depression

Any behavioral problems? Yes No **If yes, please describe:** _____

Trauma History

Any traumas during pregnancy? Yes No **Any evidence of birth trauma? (bruises, odd head shape, fast or excessively long birth, cord around neck, torticollis, collar bone damage, etc.)** Yes No **If yes, what kind:**_____

List any significant falls or impacts (from changing tables, trees, ladders, bikes, car accidents, etc.): _____

List any traumas requiring stitches, casts, etc.: _____

List any hospitalizations or surgeries: _____

List any sports played, including # of hours per week played: _____

Age your child began sports: _____ **Approximate weight of school backpack:** _____

Please list any questions you have: _____

_____

I hereby authorize and consent to chiropractic evaluation and care of my child's condition, as the Doctor deems appropriate, through use of chiropractic manipulation throughout his/her spine and/or extremities. Any x-ray negatives will remain the property of Advanced Spinal Fitness, being on file where they may be seen at any time while my child is a patient at this office. I also agree that I am responsible for all bills incurred at this office.

Parent or Guardian's Signature Authorizing Care_____ Date _____