maxliving™ STAGECOACH FAMILY CHIROPRACTIC

Pediatric History Form

Patient information:

Child's Name_____ Parent(s)/Guardian Name_____

Address_____ City_____ State_____ Zip_____

Home phone_____ Work phone_____ Cell phone_____

Is it okay to text you appointment reminders? Yes___ No___

Email_____ Birthdate _____ Age_____ Gender M___ F___

Does your child have insurance coverage? Yes___ No ___

Have you or your child ever had chiropractic care in the past?_____

If yes, what was the doctor's name: _____

Were you pleased with your care? _____

How did you find out about about office? _____

Who is your family's primary care doctor?_____

Please list any medications your child is taking_____

Please list any vitamins/herbs/supplements your child is taking_____

Please list any allergies your child has_____

Current Health:

What health condition brings your child into our office _____

_____

When did the symptoms first begin? _____

How did the problem start? Suddenly___ Gradually___ Post-injury___

Is the condition: Getting worse___ Improving___ Intermittent___ Constant___ Not Sure___

What makes the problem better? _____

What makes the problem worse? _____

Has your child ever had similar conditions? Yes___ No ___

If yes, please explain _____

Has your child every been treated for this before? Yes___ No ___

If yes, please explain _____

Does your child eat well? Yes___ No ___

Does you child have regular bowel movements? Yes___ No ___

Has your child ever been check for vertebral subluxation? Yes___ No ___ Don't know___

Health History:

Child's birth was: At home___ At a birthing center___ At a hospital___

My OBGYN/Midwife was_____

Child birth was:

Natural vaginal (no medications/interventions) ___

Natural with interventions_____

Induction__ Pain medication__ Epidural__ Episiotomy__ Vacuum extraction__ Forceps__

C-section __

Please list reason for any interventions/complications_____

_____

Child's birth weight____ Child's birth height____ Child's current weight____ Child's current height____

Growth and Development:

Was your child alert and responsive within 12 hours of delivery? Yes____ No____

If no, please explain:_____

At what age did your child:

Respond to sound___ Follow an object___ Hold head up___. Vocalize___

Sit alone___ Teethe___ Crawl___ Walk___

Patient hospitalization/surgical history:_____

_____

Please list any major accidents, falls, or fractures your child had_____

_____

Is/was your child breastfed? Yes___ No___ If so, how long?_____

Formula introduced at age?_____ What kind_____

Introduction of cow's milk at age_____ Started solids at age_____

Please list any food/juice intolerances_____

Did mother smoke during pregnancy? Yes___ No___

Did mother drink alcohol during pregnancy? Yes___ No___

Any drugs/medications taken during pregnancy (including over the counter)_____

_____

List any supplements taken during pregnancy_____

_____

Did you baby have any exposure to ultrasounds? Yes___ No___

If yes, how many?_____

Is your child exposed to any pets in the home? Yes___ No___

Is your child exposed to any smoke in the home Yes___ No___

Has your child had any vaccinations? Yes___ No___

If yes, list which ones and list any reactions_____

_____

Has your child had any antibiotics? Yes___ No___

If yes, list how many times and reasons_____

Any difficulty breastfeeding? Yes___ No___

If yes, please explain _____

Any difficulty bonding? Yes___ No___

If yes, please explain _____

Any behavioral problems? Yes___ No___

If yes, please explain _____

Any night terrors, sleepwalking, or difficulty sleeping? Yes___ No___

If yes, please explain _____

Average amount of screen time per day_____

Chiropractic Basics:

Do you know what subluxation is? Yes___ No___

Are you seeking chiropractic for: Optimal health/maintenance___ Health problems___ Both___

What would you like your child to gain from chiropractic care_____

_____

Are there any other health concerns or anything else you would like us to know about your child?

_____

_____

I understand that I am directly and fully responsible to Stagecoach Family 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's / Guardian's signature Date

_____ _____

Doctor's signature Date