Rooted Chiropractic
HEALTH . FAITH . RESULTS

# 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 is 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.

**Child's Legal Name:**_____ **DOB:** _____**Today's Date:** _____

Male/ Female (Circle one) Weight: _____lbs. Height:_____ft_____in.

Mom Name & Phone #_____ Dad Name & Phone #: _____

Address:_____City:_____State:_____ Zip:_____

How did you hear about our office? _____ If referred, by who:_____

Involved in any trauma(s): What & When?_____

_____

Previous Chiropractic Care? Y/ N Where? _____

Last Visit: _____ Xrays taken? Y/N When? _____ How often did you get adjusted? _____

**Lifestyle**- please check what applies:

Does your child: ☐ Eat health foods (organic products, etc.) ☐ Drink water

☐ Take vitamins Type: _____ ☐ Take probiotics

Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Hobbies/interests/Sports: _____

**Health Concerns:**

| Concerns: In order of importance | Severity: 1=Mild 10=Unbearable | How long have you had this? | Did this start with an injury? | Describe it Ex: Numb, Tingling, Sharp, Dull, Achy, Traveling |
|---|---|---|---|---|
| 1._____ | _____ | _____ | _____ | _____ |
| 2._____ | _____ | _____ | _____ | _____ |
| 3._____ | _____ | _____ | _____ | _____ |
| 4._____ | _____ | _____ | _____ | _____ |
| 5._____ | _____ | _____ | _____ | _____ |

Other doctors seen for these condition(s)? Y/ N Doctor's names and prior treatment:

_____

_____

# Pediatric History Form (continued)

**Prenatal History**

Name of Obstetrician/Midwife: _____ Ultrasounds during pregnancy? Y/N How many?_____

Complications during pregnancy/delivery? Y/N Explain:

_____

Medications taken during pregnancy/ delivery? Y/N List:

_____

Cigarette/ Alcohol use during pregnancy? Y/N Location of birth (circle one): Hospital Birth Center Home

Birth Intervention (circle one): Forceps Vacuum Extraction Caesarian Section (Emergency or Planned?)

Genetic disorders/ disabilities? Y/N List:

_____

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

**Feeding History**

Breast Fed: Y/N How long? _____ Formula Fed: Y/N How long? _____ Type:_____

Introduced to: Solid Foods @_____months Cow's milk @_____months

Food/ Juice allergies or intolerances: Y/N List:_____

**Developmental History**

Your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

At what age was your child able to:

_____ Respond to stimuli _____ Cross Crawl _____ Stand alone

_____ Respond to visual stimuli _____ Hold head up _____ Walk alone _____ Sit up

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? Y/N Explain:_____

Has your child been seen by a physician on an emergency basis? Y/N
Explain:_____

Name of Pediatrician: _____ Last Visit: _____

Are you satisfied with the care your child has received at the pediatrician? Y/N

# 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.) _____

Is there anything else you would like us to know about your child?

_____

_____

Parent/Guardian name: _____Signature: _____

**Child's Name**: _____ **DOB:** _____ **Date:** _____

Please check off any of the conditions below that your child (or your family) has or have had in the past:

| | Child | Sibling(s) | Mother | Father | Grandparents |
|---|---|---|---|---|---|
| Allergies/Sinus | | | | | |
| Anxiety | | | | | |
| Asthma | | | | | |
| Arthritis | | | | | |
| TMJ | | | | | |
| Acid Reflux | | | | | |
| Epilepsy | | | | | |
| Ulcers | | | | | |
| Dizziness | | | | | |
| Headaches | | | | | |
| Vertigo | | | | | |
| Nervousness | | | | | |
| Abnormal Menstrual | | | | | |
| Nausea | | | | | |
| Lupus | | | | | |
| Fatigue | | | | | |
| Psoriasis | | | | | |
| Numbness | | | | | |
| Ear Infections | | | | | |
| Migraines | | | | | |
| Kidney Condition | | | | | |
| Liver Disease | | | | | |
| Fainting | | | | | |
| Disc Problems | | | | | |
| Stiffness | | | | | |
| Irritable Bowel | | | | | |
| Stomach Condition | | | | | |
| Colic | | | | | |
| Bed Wetting | | | | | |
| Temper Tantrums | | | | | |
| Growing Pains | | | | | |
| Seizures | | | | | |
| ADD/ADHD | | | | | |
| Recurrent Fevers | | | | | |
| Chronic Colds | | | | | |

WRITTEN CONSENT FOR A CHILD/MINOR

**NAME OF PATIENT WHO IS A MINOR/CHILD**:_____

I authorize the staff at Rooted Chiropractic to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child.

**HIPAA Policy**

This notice was published and becomes effective on/or before April 14, 2003
We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

**Financial Policy**

We do our best to get your insurance coverage before coming into our office by contacting your insurance company. Please note this is NOT a guarantee of benefits. You must understand that we do not promise that an insurance company will reimburse this practice or you for the services rendered and ultimately in the event that an insurance company denies payment, it is the responsibility of you to pay the charges and seek reimbursement from your insurance company. It is your responsibility to let Rooted Chiropractic know if you insurance policy has changed. Account balances over 30 days will be charged to your credit card unless prior arrangements have been made.

As of this date, I have legal right to select and authorize health care services for my minor/child. If my authority to authorize care is revoked or altered, I will immediately notify Rooted Chiropractic.

**Guardian Signature:** _____**Date:** _____

**Guardian's Relationship to Minor/Child**_____

**Witness Signature (office staff)** _____

**Family Permission**

I give permission for Rooted Chiropractic to talk to anyone listed on my forms about my care. If that preference was to change, it is my responsibility to let you know.

**Model Release**

For valuable consideration received, I hereby grant to Rooted Chiropractic the irrevocable and unrestricted right to use and publish photographs of my child, or in which we may be included, for editorial trade, advertising and any other purpose and in any manner and medium; and to alter the same without restriction. I hereby release photographer and her legal representatives and assigns from all claims and liability relating to said photographs.

**Child's Name:** _____

**Guardian's Name:** _____

**Signature** _____ **Date:** _____