Name: ________________________ Today's Date: _____________________

# Pediatric Personal Information

Full Legal Name ___________________ Preferred Name _______________ Date of Birth: _____________

Age: _________ Sex: □ Male □ Female Address: ______________________________________________

City: ________________________________ Zip: _____________ Social Security # ___________________

Cell Phone ( ) ______-_________ Work/Home Phone ( ) ______-_________

E-mail Address ______________________________________________

Parent(s)/Guardian(s) Name _____________________________________________________________

What is the best way to contact you? □ Phone □ E-mail □ Text

Who may we thank for referring you? _______________________________________________________

Emergency Contact, Name & Phone # _______________________________________________________

Parents Occupation: __________________ Parents Employer: __________________________________

Parents Employer's Address: ______________________________________________________________

Health Insurance Company: _______________________________ Phone # _______________________

Health Insurance ID# ____________________________ Group # _________________________________

**Primary Reason for Contacting Our Office** _____________________________________________

□ Mild □ Moderate □ Severe **Since onset is it**: □ Getting better □ Getting Worse □ Staying the Same

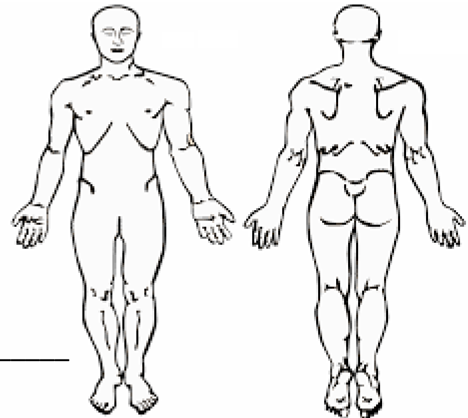
**Is the purpose of the visit related to** □ Sports □ Auto □ Home Injury □ Fall □ Wellness/prevention

**Date of Injury**: _____________ If no injury, when did the problem begin ___________________________

**List any symptoms experienced *(check more than one if necessary to describe the problem)***

□ Sharp □ Dull □ Burning □ Numbness □ Tingling □ Pressure

□Travels □ Constant □ Worst at Night □ Worst in Daytime



**Please mark on diagram where you are experiencing symptoms**

What makes it better ____________________________

What makes it worse ____________________________

**Has this condition occurred before?** □ Yes □ No

If yes, please explain ___________________________________

**List any activities of daily living effected**

□ Sleep □ School □ Daily Routine □ Other ____________

**Discover Chiropractic**
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www.discoverbendchiro.com

DISCOVER CHIROPRACTIC

Name: ________________________ Today's Date: _____________________

**Mother's Pregnancy and Labor**

Child's birth was: □ At Home □ At a Birthing Center □ At a Hospital

My obstetrician/midwife/family physician was: ________________________________________________

Birth Process: □ Natural vaginal (no medications/interventions) □ C-section (□ scheduled □ emergency)

□ Vaginal with interventions (□ induction □ pain med □ epidural □ vacuum □ forceps)

Gestational age at birth _________________ APGAR score at birth (if known) ______________________

Birth weight _________ Birth height _________ Current weight __________ Current height __________

At what age did the child:

Respond to sound ________ Follow an object _______ Hold head up _______ Vocalize _______

Sit alone _______ Teethe _______ Crawl _______ Walk _______

Is/was your child breast fed? □ Yes □ No If yes, how long ______ If no, age formula introduced ______

If cow's milk introduced, what age __________ Age child began eating solid foods _________

Food sensitivities (please list) ______________________________________________________________

Did the mother smoke during pregnancy? □ Yes □ No

Did the mother drink alcohol during pregnancy? □ Yes □ No

List any drugs/medications (including over the counter) taken during pregnancy ____________________

_____________________________________________________________________________________

Has the child received any vaccinations? □ Yes □ No

If yes, which ones and list any reactions _____________________________________________________

Has the child received antibiotics □ Yes □ No If yes, how many times ____________________________

Any behavioral problems? □ Yes □ No If yes, please explain __________________________________

Does your child seem normal for their age? □ Yes □ No If no, please explain _____________________

_____________________________________________________________________________________

**Past Medical History**

List any that apply *(mark with a [P] for past or [C] for current)*

□ Vision problems □ Tubes in the ears □ Allergies □ Hyperactivity □ Breathing problems

□ Headaches □ Drug reactions □ Asthma □ Ear problems □ Sleeping disorders

□ Attention problems □ Food reactions □ Colic □ Constipation □ Frequent colds

□ Digestive problems □ Environmental issues □ Pink eye □ Irritability □ Skin problems

□ Other ___________________________________________________________________________

_____________________________________________________________________________________

Surgeries/Operations (type and date): ____________________________________________________

_____________________________________________________________________________________

Significant Traumas: (include date): _____________________________________________________

_____________________________________________________________________________________

Prescription and Over the Counter Medication (name and duration): ____________________________

_____________________________________________________________________________________

Allergies: □ Food □ Medication □ Environmental Please describe ____________________________

DISCOVER CHIROPRACTIC

Name: ________________________ Today's Date: _____________________

**Family Medical History**

List any that apply *(mark with a [F] for Father, [M] for Mother, [S] for Sibling or [G] for Grandparent)*

□ Cancer □ Heart disease □ Asthma □ Diabetes □ Stroke □ Depression
□ Allergies □ High Blood Pressure □ Seizures □ Other ___________________________________

**Goals for Child's Care**

Children see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain, others for correction of whatever is malfunctioning in their bodies and some for prevention and wellness. Your doctor will weigh your needs and desires when recommending a care program for your child. Please check the type of care the most closely describes the type of care you desire.

□ **Relief** – Symptomatic relief of pain or discomfort
□ **Corrective** – Correcting and relieving the cause of the problem as well as the symptoms
□ **Prevention and Wellness** – Regardless of symptoms we strive to restore neurologic balance and help your child reach and maintain their highest heath potential.

**Authorization to Care for a Minor Child**

I hereby authorize the doctor to treat my child (name) ___________________________ as he/she deems appropriate through the use of, but not limited to, spinal adjustments.

I understand and agree that healh and accident insurance policies are an arrangement between an insurance carrier and myself. The doctor's office may bill my insurance as a courtesy to me and will prepare any necessary reports and forms (fees may apply) to assist in making collection from the insurance company. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment of all fees for service including legal fees, collection agency fees, and any other expenses incurred in collecting my account. I also understand and agree that if I suspend or terminate care any fees for services rendered to me will be immediately due and payable.

It is understood and agreed that any x-rays will remain property of this office, being on file where they may be seen at any time. The client also agrees that he/she is responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patients Name (print) ______________________________________________ Date ____________________

Parent/Legal Guardian Name (print) ____________________________ Signature _____________________