Pediatric History Form

LIMITLESS
CHIROPRACTIC

Understanding the Importance of Chiropractic Care: *You were born to be healthy all of your life. Good health depends upon everything in your body being connected to your brain by nerves that pass between the bones of your spine. A subluxation is a disconnection between your brain and body affecting your health. Chiropractic restores this connection.*

About the Patient

Child's Name:______________________ Age:________ Today's Date:__________

DOB:___/___/______ **At birth:** Height: ____ Weight: ____ Weeks gestation:____ Labor hrs: ______

Gender: ☐ M ☐ F Phone (Home): ______________ Current Height:______ Current Weight: ______

Address:______________________ City: ______________ State: ______ Zip: ______

Email: ______________________ Referred by:______________________

Mother's Name:______________ DOB:__________ Mother's Mobile:__________

Father's Name: ______________ DOB: __________ Father's Mobile: __________

Pediatrician/Family MD: ______________________ Last Visit:__________

Reason for Visit: ______________________ Any previous chiropractic care? ☐ Yes ☐ No

Who is responsible for this bill?______________ Vaccinations: ☐ Yes ☐ No ☐ Delayed

Please list any medications: ______________________________

Present Complaints

Reason for seeking care: ☐ Wellness Check-up ☐ Injury or Accident ☐ Other______________

Please explain: ______________________________

If your child is experiencing *Pain/Discomfort* please identify where:______________________

When did the Problem first begin? Date: ___/___/____ ☐ Unknown

This problem come on: ☐ Gradually ☐ Suddenly

Ever had this problem before? ☐ No ☐ Yes If yes, when? ________

Any bowel or bladder problems since this problem began?: ☐ No ☐Yes

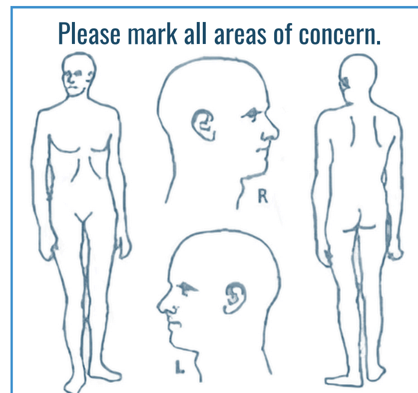
If yes, describe: ______________________

Have you seen any other doctors for this problem? ☐ No ☐ Yes

If yes, who and when? ______________________

What were the results of past treatment? ______________

____



How is this problem NOW?: ☐ Rapidly Improving ☐ Improving Slowly

☐ About the Same ☐ Gradually Worsening ☐ On & Off

Please list any medication taken for this problem:______________________

Has your child ever sustained an injury playing organized sports? ☐ No ☐ Yes

If yes, please explain:______________________________

Has your child ever sustained an injury in an auto accident? ☐ No ☐ Yes

If yes; please explain:______________________________

Location of birth: ☐ Hospital ☐ Birthing Center ☐ Home OBGYN/Midwife: ______________

Birth: ☐ Vaginal w/epidural ☐ Natural w/o epidural ☐ C-section

Were forceps or vacuum used? ☐ No ☐ Yes How long was labor process?______________

Feeding: ☐ Breast fed ☐ Formula

How was the pregnancy? (Complications, Ultrasounds, etc.): ______________________

____

How was the child's birth process?: ______________________

____

Family History

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other: __________

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other: __________

Is there any other family history you want us to know?______________________

____

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LIMITLESS CHIROPRACTIC

Child's Medical History

Has your child ever experienced any of the following? *Please check all that apply*:

☐ Headaches
☐ Orthopedic Problems
☐ Digestive Disorders
☐ Behavioral Problems
☐ Dizziness
☐ Neck Problems
☐ Poor Appetite
☐ADD/ADHD
☐ Fainting
☐ Arm Problems
☐Stomach Aches
☐ Ruptures/Hernia
☐ Seizures/Convulsions
☐ Leg Problems
☐Reflux

☐ Muscle Pain
☐ Heart Trouble
☐ Joint Problems
☐ Constipation
☐ Growing Pains
☐ Chronic Earaches
☐ Backaches
☐ Diarrhea
☐ Asthma
☐ Sinus Trouble
☐ Poor Posture
☐ Hypertension
☐ Walking Trouble
☐ Scoliosis
☐ Anemia

☐ Colds/Flu
☐ Sleeping Problems
☐ Bed Wetting
☐ Colic
☐ Broken Bones
☐ Fall off swing
☐ Fall in baby walker
☐ Fall from bed or couch
☐ Fall from crib
☐ Fall down stairs
☐ Fall off bicycle
☐ Fall from high chair
☐ Fall off slide
☐ Fall from changing table
☐ Fall off monkey bars
☐ Fall off skateboard/skates

Additional Health Information

Does your child have any ongoing medical conditions not mentioned above? If yes, please describe: ________________________

____

Allergies (please specify): ____

Other Medical Conditions or Concerns: ______________________________________

Any current medications or supplements? Please list: ___________________________

____

Authorization and Consent

I understand that I am directly and fully responsible to Limitless 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 or Legal Guardian's Signature Date

____

Doctor's Signature Date

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