Pediatric History

The New York Chiropractic Life Center

(ages 1 day to 17 yrs)

Name: _____ **Age:** _____ **Birthday:** _____ **Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Parents names: _____ _____

Home #:_____ **Cell #**_____ **Email:** _____

Reason for consulting our office: _____

Whom can we thank for referring you? _____

Health Profile

Why is this form important?

As a family chiropractic office, we focus on your child's ability to be healthy. Our goals are first, to address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health and wellness care.

If your child has no symptoms or complaints, and is here for wellness services, please check ☐
Others need to briefely describe the chief area of complaint, including the effect it has on the child. _____

_____

How long has the problem been present? _____

If he/she is experiencing pain, is it: ☐Sharp ☐Dull ☐Comes and Goes ☐Travels ☐Constant

Since the problem started, is it: ☐Getting better ☐Getting worse ☐About the same

What makes it worse? _____

Does it interfere with: ☐School ☐Sleep ☐Walking ☐Sitting ☐Sports ☐Others _____

Other doctors seen for this problem:

Chiropractor: _____

Pediatrician: _____

Other: _____

May we contact them for this case? ☐Yes ☐No

List any medications the child is taking, or surgeries the child has had: _____

_____

Name: _____

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to your child's health potential.

Pregnancy:

Any Complications? _____

Was Mom on any medications, prescriptions or over-the-counter? □Yes □No

If yes, explain: _____

Did Mom or Dad smoke during pregnancy? □Yes □No **Who?** _____

Was your baby ever in the breech position? □Yes □No

How many ultrasounds were performed? _____

Birth and Delivery:

Where was your baby born? □Home □Hospital □Birthing Center □Other: _____

Was your delivery: □Vaginal □C-section

Were any devices used? □Forceps □Vacuum

How long was your labor? _____ **How long was the delivery?** _____

Was oxytocin/ptosin used? □Yes □No

Infancy:

Was your infant vaccinated? □Yes □No

Infant feeding: □Breastfeeding, how long _____ □Bottle □Formula

Was there any prolonged use of medicines or an inhaler? □Yes (circle one) □No

Did your infant suffer any traumas, such as serious falls or car accident? □Yes □No

Has your infant been under regular chiropractic care? □Yes □No

Childhood years:

Did your child have any childhood illnesses? □Yes □No **Explain:** _____

Did your child have any any falls over 3 feet? □Yes □No **Explain:** _____

Was your child in any car accidents? □Yes □No **Explain:** _____

Has there been any prolonged use of medicine? □Yes □No **Explain:** _____

Has your child suffered emotional trauma? □Yes □No **Explain:** _____

Please give us any other information that may be helpful: _____

The statements made on this form are accurate to the best of my recollection and I request and give consent to this office to chiropractically examine and care for my child.

Parent's Signature: _____ **Date:** _____