REVOLUTION
CHIROPRACTIC

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 Name:__________________________ Today's Date:____________________________

Birth Date: / / Male/Female (Circle one) Weight: lbs. Height: ft. in.

Parent/ Guardian Name: ____

Phone number: __________________Parent/Guardian Social Security Number: ___________________

Address: ___________________________________City: ________________State: _____ Zip: ___________

Referred by: ____

Reason for pursuing care: ____

Family history:____

Check any of the following conditions that currently apply:

_____Ear infections _____Scoliosis _____Chronic Colds ___Headaches
_____Allergies _____Digestive problems _____ADHD/ADD ___Recurring Fevers
_____Colic _____Reflux _____Bed wetting ____Temper Tantrums
_____Seizures _____Asthma _____Car accident (Please include when) _____________
Other 1: ______________________________ Other 2: _______________________

Other doctors seen for this condition (Please include doctor's names and prior treatment):

____

Previous Chiropractic Care? Y/ N Last visit: __/__/___

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 ______________

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Present prescription drugs/ dosage? ____

Past prescription drugs/ dosage? ____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.)____

Prenatal History

Name of Obstetrician/ Midwife: ____

Complications during pregnancy/ delivery? Y/N Explain: ____________________________________

Ultrasounds during pregnancy? Y/N How many? ____

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

Cigarette/ Alcohol use during pregnancy? Y/N

Location of birth (circle one): Hospital Birthing Center Home

Birth Intervention (circle one): Induced Forceps Vacuum Caesarian Section

If Caesarian Section, was it (circle one): Emergency 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

(to the best of your knowledge)

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

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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 above?

Y/N Explain: ____

Other traumas not described above (bike wipeout, trampoline injury, etc.)?

____

Has your child been involved in any sports? Y/N List: ____

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

____

Lifestyle

(please check all that apply)

Does your child: ☐eat healthy food (organic products, etc.) ☐drink water ☐take probiotics ☐take vitamins Type: __________

Exercise: ☐none ☐mild ☐moderate ☐heavy ☐daily

Hobbies/ interests: ____

____

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

____

Parent/ Guardian name:______________________________ Signature: ______________________________

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We love to have kid's pictures in our office! If you would allow us to have your child's picture in the office, please sign below.

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Revolution Chiropractic LLC, or anyone authorized by Revolution Chiropractic LLC, of any and all photographs/videos which were taken of my child, for the purposed of promotional TV, website, social media and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute the property of Revolution Chiropractic LLC, solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentially, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Revolution Chiropractic LLC. to share this information via their website and their Facebook/social media including Twitter and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws).

Signature:____Date: __________________________

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF THE X-RAYS IN OUR FILES.

PLEASE NOTE: IF X-RAYS ARE NECESSARY, THEY ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF REVOLUTION CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

IF YOUR CHILD IS AN INFANT OR UNDER THE AGE OF FIVE, IT IS UNLIKELY THEY WILL NEED CHIROPRACTIC POSTURAL XRAYS. HOWEVER, PLEASE SIGN BELOW FOR FUTURE REFERENCE.

BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS

CHILDS NAME____CHILDS AGE _____________________

PARENT/GARDIAN SIGNATURE______________________________________DATE ________________

DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE

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