PRECISION UPPER CERVICAL

HEALTH SOLUTIONS

Pediatric Health History

Date_____
Phone Number_____
Patient Name_____
Preferred Name _____
Parents/Guardian Names _____
Address_____ Date for birth_____ Age_____
City_____State_____Zip_____ Sex __M__F S.S.# _____
Guardian's E-mail_____
Referred by_____ Previous Chiropractic Care? Y N When?
_____Where?_____Who?_____

Please check reasons for pursuing chiropractic care for your child
___She/He is continuing ongoing care from another chiropractor
___I recently had spine checked and I see the value in getting my child checked.
___I'm concerned about his/her health and I am looking for answers.
___She/He has a specific condition that concerns me.(briefly explain)_____
___I want to improve my child's immune function.
___Wellness

In order for us to better understand your child's current level of health, please check any of the following body signals which your child has or has had previously:
__Headaches __Postural __Asthma __Allergies
__Ear infection __Scoliosis __ADD/ADH __PDD/Autism
__Seizures __Growing Pains __Back Pains __Car accident __Colic
__Frequent Colds __Sinus Problems __Bedwetting __Digestive Problems
Other:_____

List Prescription and Over The Counter Medications Now Taken:

Known Allergies: _____

Number of doses of Antibiotics Your Child has Taken:
During the past 6 months:_____
Total during his/her lifetime: _____
List reasons:_____
Number of doses of other Prescription Medications Taken:
During the past 6 months:_____
Total during his/her lifetime: _____
List reasons:_____

Prenatal History

Adopted? ___Yes ___ No
Complications during pregnancy? ___Yes ___ No
List:_____
Ultrasounds during pregnancy? ___Yes ___ No Number:_____
Medications/drugs/caffeine during pregnancy? ___ Yes ___ No
List:_____
Cigarette / Alcohol use during pregnancy? ___ Yes ___ No
Location of Birth: ___ Hospital ___ Birthing Center ___Home

Birth Intervention

__Mother induced __Mother medicated (Pitocin, etc) __Caesarian Section
__Forceps __Vacuum extracted
__Baby given medications after delivery:_____

Complications during delivery? __Yes __No List: _____
Genetic disorders or disabilities? __Yes __No List: _____

Breast Fed? ____Yes ____No How long? _____
Formula Fed? ____Yes ____No How long?_____
Food Allergies or Intolerances?_____

According to the National Safety Council, approximately 50% of children head fall first from a high place during the first year of life. (i.e., a bed, changing table, down stairs, etc.) Was this the case with your child? __Yes __ No
List: _____

Is/Has your child been involved in any high impact or contact type sports? (i.e., soccer, football, gymnastics, hockey, baseball, cheerleading, martial arts, etc.) __Yes __ No
List: _____

Has your child been seen on an emergency basis? __Yes __ No
List: _____
Prior surgery? __ Yes __ No
List: _____

It is important that our patients and we have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe that the greatest Doctor is the one already inside each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept for your child, if eligible, chiropractic care on this basis.

_____ _____

Parent / Guardian Signature Date