DATE: ____/____/_____

Patient File Number _____

PEDIATRIC HEALTH HISTORY Ages 4-10 years

Thank you for choosing Crossroads Family Chiropractic for your health concerns! Dr. Keen is honored to be a coach in getting your child on a path to a healthier lifestyle. Please fill out the following form as thoroughly as possible so that the doctor may better serve your needs.

PERSONAL INFORMATION

Child's Name_____ Age _____ Date of Birth ___/___/_____ Sex _____

Home Address_____ City_____State____ Zip_____

FAMILY INFORMATION

Father's Name_____ Mother's Name_____

Father's Cell Phone (_____) _____ Mother's Cell Phone (_____) _____

Father's Work Phone (_____) _____ Mother's Work Phone (_____) _____

Home Phone (_____) _____ E-mail _____

Parent's Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed □ Living Together

Who may we thank for referring you to the office? _____

Do we have your authorization to thank them for referring you? Yes No

Would you like to receive our newsletter? (Whole foods recipes, health devotionals, office updates/promotions, etc) Yes No

Would you like to receive text reminders for upcoming appointments? Yes No

If so, please list your provider: _____

RELEASE

I, the undersigned, authorize the Dr. and her staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photo static copy of this agreement shall serve as the original.

X_____

Patient or Guardian's Signature Relationship to Patient Date

DATE: ____/____/_____

Patient File Number: _____

Pediatric Health History – Age 4-10

REASONS FOR SEEKING CHIROPRACTIC CARE

At Crossroads Family Chiropractic, our goals are to first address the issues that brought your child to this office, and second, to offer your child the opportunity of improved health, wellness, and quality of life in the future.

Please briefly describe the main concern that you would like us to address for your child.

_____

Are these concerns affecting your child's quality of life? (check all that apply) □ Eating □ Sleep □ Other _____

HEALTH CARE PRACTITIONER HISTORY

Other doctors seen for this condition: □ Chiropractor □ Medical Doctor □ Other

Has your child ever had chiropractic care? □ No □ Yes Name of D.C._____

How long under care? □ _____days □ _____weeks □ _____months □ _____years

Date of last visit_____ Why was care stopped? _____

Are you satisfied with the care your child received there? □ No □ Yes

Name of Pediatrician _____ City _____
Date of last visit _____/_____/_____ Reason _____
Are you satisfied with the care your child has received there? □ Yes □ No

Do you authorize our office to contact your child's doctors to discuss previous medical care?

YOUR CHILD'S HEALTH PROFILE

The information below will help us to see the PHYSICAL, CHEMICAL & EMOTIONAL stresses your child has been subjected to and how these stresses may relate to his/her present spinal, nerve, and health status.

General History

Please mark all symptoms your child has ever had, even if they do not seem related to the current problem.

□ Ear infections	□ Scoliosis	□ Seizures	□ Chronic Colds
□ Headaches	□ Asthma	□ Allergies	□ Digestive problems
□ ADD/ADHD	□ Recurrent fevers	□ Growing pains	□ Colic
□ Bedwetting	□ Anemia	□ Reflux	□ Behavioral problems
□ Leg problems	□ Poor posture	□ Diabetes	□ Heart trouble
□ Stomach aches	□ Muscle pain	□ Orthopedic problem	□ Neck problems

□ Joint problems □ Constipation □ Diarrhea □ Poor appetite □ Arm problems □ Back problems □ Trouble walking □ Sinus problems

Please list any other serious medical condition(s) your child currently has or has ever had:

_____

Prenatal History

Name of Obstetrician/Midwife _____

Social history while pregnant:

Did you: □ Exercise regularly □ Eat a balanced diet □ Obtain sufficient rest

Did you smoke? □ No □ Yes – How many packs per day _____

Did you drink alcohol? □ No □ Yes – How many drinks per day _____

Did you drink caffeine? □ No □ Yes – In what form (coffee, tea, etc.) _____

DATE: ____/____/_____

Patient File Number: _____

Pediatric Health History – Age 4-10

Medications/Supplements while pregnant – please list

_____ _____

_____ _____

Were there complications during pregnancy? □ No □ Yes, Please explain: _____

_____

Labor and Delivery:

Location of birth: □ Hospital □ Birthing Center □ Home

Birth Intervention: □ Forceps □ Vacuum extraction □ Cesarean section (Emergency or Planned)

Were there complications during delivery? □ No □ Yes - Please explain: _____

_____

Birth Weight (pounds) _____ Birth Length (inches) _____ APGAR Scores _____

Feeding History

Breast Fed: □ No □ Yes – How long? _____months

Formula Fed: □ No □ Yes – How long? _____months Formula Brand: _____

Does baby prefer feeding on one side more than the other? □ No □ Yes – Which side? _____

After a feeding does the baby frequently spit-up? □ No □ Yes

Introduced to solids at _____ months Introduced to cow's milk at _____ months

Food/Drink allergies, sensitivities or intolerances: □ No □ Yes – Please list: _____

_____

PHYSICAL STRESS

Has your child ever suffered from the following spinal traumas?

□ Fall in baby walker □ Fall from bed or couch □ Fall off swing □ Fall from crib

□ Fall from highchair □ Fall off slide □ Fall down stairs □ Fall off changing table

□ Other _____

Has your child ever been in a car accident? □ No □ Yes – please explain _____

Has your child ever had a bone fracture or joint dislocation? □ No □ Yes – please explain _____

_____

Does your child sleep through the night? □ No □ Yes – please explain: _____

On average how many hours of sleep does your child get per night? _____

CHEMICAL STRESS

Vaccination history: □ up to date □ chose to decline vaccinations □ Other _____

□ still deciding on which vaccinations and at what age to allow administration

□ *I would like more information on the adverse reactions and potential dangers of vaccinations.*

Please describe any adverse reactions to any vaccinations: _____

Number of doses of antibiotics your child has taken: During the past 6 months _____ Total during lifetime _____

DATE: ____/____/_____

Patient File Number: _____

Pediatric Health History – Age 4-10

Please list any drugs or medications (prescription or over-the-counter) your child is taking and the reason why.

_____ _____

_____ _____

Please list any vitamins, supplements, herbs, homeopathics, etc. that your child is taking and the reason why.

_____ _____

_____ _____

Do you have any concerns with your child's diet? □ No □ Yes – please explain: _____

_____

EMOTIONAL STRESS

Does your child have difficulty concentrating? □ No □ Yes – please explain: _____

_____

Does your child get angry easily? □ No □ Yes – please explain: _____

_____

ADDITIONAL QUESTIONS

If there is a need for dietary changes or nutrients, would you like to be informed? □ Yes □ No

If there is a need for specific exercises, would you like to be informed? □ Yes □ No

If there is a need for support in the emotional/stress area of health, would you like to be informed? □ Yes □ No

Is there any specific health topic you would like more information on? _____

EXPECTATIONS

I would like my child to have the following benefits from Chiropractic Care: (check all that apply)

□ Relief of a symptom or problem

□ Relief and Prevention of a symptom or problem

□ Healthier spine and nerve system

□ Best possible health on all levels

Thank you for choosing Crossroads Family Chiropractic!

We look forward to guiding you and your child to a healthier future.