Langley Family Chiropractic – Pediatric Form

The purpose of this office is to educate as many families as possible about the spinal condition known as Vertebral Subluxations. Vertebral Subluxations damages an optimally functioning spine and your ability to have optimal health. Your experience with this office will not only be of healing but also of learning the truth about **Optimal Health and Healing**.

Patient Name____ SS#___________________________

Name of Parents / Guardians____

Address____City_________________State_________Zip________________

Home Phone___________________ Parent Work Phone______________________ Email Address____________________________

Birth Date____/_____/________ Sex___________ Weight______________ Height__________ Number of siblings___________

How did you hear about our office? ____

Reason for seeking chiropractic care:____

Other Doctors seen for this condition ____Y ____N

Dr.'s Name and prior treatment ____

Other Health Problems____

Has your child ever suffered from: (Check all that apply)

☐ Dizziness	☐ Backaches	☐ Heart trouble	☐ Chronic earaches
☐ Diabetes	☐ Tuberculosis	☐ Hypertension	☐ Colds / Flu
☐ Arthritis	☐ Headaches	☐ Asthma	☐ Allergies
☐ Neuritis	☐ Digestive Disorders	☐ Sinus trouble	☐ Constipation
☐ Anemia	☐ Rheumatic Fever	☐ Orthopedic problems	☐ Diarrhea
☐ Poor Appetite	☐ Hyperactivity	☐ Sugar concentration	☐ Behavioral problems
☐ Bed Wetting	☐ Convulsions	☐ Paralysis	☐ Muscle jerking
☐ Fainting	☐ Walking problems	☐ Broken bones	☐ Ruptures / Hernias
☐ Neck Problems	☐ Arm problems	☐ Leg problems	☐ "Growing pains"
☐ Joint Problems	☐ Blood disorders	☐ Stomach aches	☐ Other______________

Family Health History: ____

Previous Chiropractor: ____ Date of last visit ___/___/______

Reason: ____

Name of Pediatrician: ____ Date of last visit ___/___/_____

Reason: ____

List any/all medications (either prescribed or OTC):____

____

____

Number of doses of antibiotics your child has taken:

During the past 6 months__________ Total during his/her lifetime____________

Vaccination history____

Prenatal History

Type of Birth Attendant: OBGYN CNM Lay Midwife Name of attendant: ______________________________________

Location of Birth: _______Home ________Birthing Center ________Hospital

Complications during pregnancy: ____Y ____N List:____

Ultrasounds during pregnancy: ____Y ____N If yes, Number: _______ Reason: ____

Medications during pregnancy / delivery: ____Y ____N List: ____

Cigarette / Alcohol use during pregnancy: ____Y ____N

Birth intervention: _____Forceps _____Vacuum _____Caesarian: Planned or Emergency ________________________________

Complications during delivery: ____Y ____N List: ____

Genetic disorders or 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 solids at _____ months; Cow's milk at _____ months

Food / juice allergies or intolerances ___Y ___N List: ____

Developmental History

Number of hours sleeping per night: ___________ Quality of sleep: Good Fair Poor

At what age was your child able to:

________ Respond to sound ________ Cross crawl

________Respond to visual stimuli ________ Stand alone

________ Hold head up ________ Walk alone

________ Sit up

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, etc.). Was this the case with your child? ____Y ____N

Is / has your child been involved in any high impact or contact type sports? ___Y ___N Type: ______________________________

Has your child ever been involved in a car accident? ___Y ___N Date:_______________________

Has your child been seen on an emergency basis? ___Y ___N Reason and Date: ___________________________________

Other traumas not described above? ___Y ___N Date: _____________________________

Prior surgery: ___Y ___N Type and Date:_________________________________ Menarche: ___Y ___N Age:_________

Childhood Diseases

Chicken Pox	N / Y	Age _______	Mumps	N / Y	Age _______
Rubella	N / Y	Age _______	Whooping cough	N / Y	Age _______
Rubeola	N / Y	Age _______	Other ________	N / Y	Age _______

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed ___________________________________Witnessed ______________________________________Date: ___/___/___