



Welcome To Four Points Family Chiropractic
New Patient Pediatric Form
Please complete all questions.\

Pediatric History Form

Today's Date: ___/___/___ Home Ph. # _____
Patient's Name: _____
What patient prefers to be called: _____
Parents / Guardian Names: _____

Mailing (Street) Address: _____
City: _____ State: _____ Zip Code: _____
Parent's email address (for patient newsletter): _____

Child's Birth Date: ___/___/___ Age: ___ Sex: ___M ___F S.S. # _____

How did you learn about our office?

Previous Chiropractic Care? ___ Yes ___ No

Approximate Last Visit Date: _____

Please check reasons for pursuing chiropractic care for your child:

- ___ *She/He is continuing ongoing care from another chiropractor.*
 - ___ *I recently had my spine checked and I see the value in getting my child checked.*
 - ___ *I'm concerned about his/her health and I'm looking for answers.*
 - ___ *She/He has a specific condition that concerns me.*
- Explain condition or symptom:

- ___ *I want to improve my child's immune function.*
- ___ *I have no idea why we're here. Please take the time to explain to me what you do for children.*

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 Imbalance ___ Asthma ___ Allergies ___ Ear Infection ___ Scoliosis
 - ___ ADD/ADHD ___ PDD/Autism ___ Seizures ___ Growing/Back Pains ___ Car Accident
 - ___ Digestive Problems ___ Frequent Colds ___ Sinus Problems ___ Bedwetting
 - ___ Colic
- Other: _____

List Prescription or 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 her/her lifetime: _____

List medications: _____



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Prenatal History:

Adopted? ___ No ___ Yes

Complications during pregnancy? ___ No ___ Yes

List: _____

Ultrasounds during pregnancy? ___ No ___ Yes Number: _____

Medications/drugs/caffeine during pregnancy? ___ No ___ Yes

List: _____

Cigarette / Alcohol use during pregnancy? ___ No ___ Yes

Location of Birth: ___ Hospital ___ Birthing Center ___ Home

Birth Intervention: ___ Mother induced ___ Mother medicated (Pitocin, etc.) ___
Cesarian Section

___ Forceps ___ Vacuum Extracted ___ Baby given medication
after delivery: _____

Complications during delivery? ___ No ___ Yes List: _____

Genetic Disorders or Disabilities? ___ No ___ Yes List: _____

Breast Fed? ___ No ___ Yes How Long? _____ Formula Fed? ___ No ___ Yes
How Long? _____

Food Allergies or Intolerances? ___ No ___ Yes List: _____

According to the National Safety Council, approximately 50% of children fall head 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?

___ No ___ Yes 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.)? ___ No ___ Yes List: _____

Has your child been seen on an Emergency Basis? ___ No ___ Yes

List: _____

Prior Surgery? ___ No ___ Yes

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)