REVOLUTION CHIROPRACTIC

Pediatric History

Please take a moment to fill out this form and sign the bottom.
Thanks!
We will take GREAT care of you here!

Child's Name _____
Date of Birth____ ____ _____ Age_____ SSN:_____

Mothers Name_____
Father's Name_____

Address_____
City _____ State _____ Zip_____
Home Phone _____ Work Phone _____ Cell Phone _____
Email address_____

Sex _____ Birth Weight_____ Current Weight_____

Type of Birth: Normal/vaginal_____ Forceps_____ Breech_____ Cesarean_____

Home_____ Hospital_____

Problems during pregnancy?_____

Problems during labor/delivery?_____

APGAR Scores: _____ _____ Present at Birth? Jaundice (yellow) ____Cyanosis (blue) _____

Congenital Anomalies/Defects: _____

Infant Feeding: Breast_____ Bottle_____ Formula_____

Quality of Sleep: Good_____ Fair_____ Poor_____

Immunization History_____

Any childhood diseases? _____

Purpose of Last Visit to MD_____ Date_____

Purpose of This Appointment_____

Development History: At what age did the child….?

Smile_____ Stand_____ Walk alone_____ Crawl_____ Hold objects with hands_____

Hold head up_____ Sit alone_____ Talk_____ Follow object with his/her eyes_____

Has this child ever suffered from: (Circle all that apply)

Dizziness	Backaches	Blood disorders	Stomachaches
Diabetes	Headaches	Heart trouble	Chronic Earaches
Anemia	Colds/Flu	Asthma	Digestive disorders
Poor appetite	Rheumatic fever	Sinus trouble	Allergies
Bed wetting	Hyperactivity	Diabetes	Constipation
Fainting	Seizures	Paralysis	Diarrhea
Neck issues	Walking issues	Broken bones	Behavioral problems
Joint issues	Arm issues	Leg issues	Ruptures/Hernias

Surgery_____

Medications_____

Accidents_____

Family History_____

Has Your Child Ever Been Treated on Emergency Basis? _____

If so, why?_____

Do you have any type of health insurance? _____ Company: _____ ID number_____

Please give us your insurance card so we may photocopy it.
Consent To Treat Minor
I hereby authorize _____ and whomever he may designate as his assistants to administer treatment, as he so deems necessary to my child, _____.

Dated _____day of _____ 20____
Signed_____
I agree to assume responsibility for any charges created by the chiropractic care, and give consent for my child to be examined and/or treated by Dr. Newsome or the staff of Revolution Chiropractic.

Parental Signature_____

Date_____