Whom may we thank for referring you to this office → _____?

Maximize Chiropractic – PEDIATRIC HEALTH HISTORY FORM

Today's Date: _____ HR#: _____

ABOUT THE CHILD

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Names and Ages of Siblings: _____

Height: _____ Weight: _____

PARENT A

Name: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

PARENT B

Name: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Maximize Chiropractic can address for your child? _____

_____

Related to: ❑ Sports ❑ Auto ❑ Fall ❑ Birth Trauma ❑ Home Injury ❑ Other _____

Please describe how these concerns are affecting your child's quality of life. _____

_____

Check all that apply

❑ School
❑ Playing
❑ Communication
❑ Exercise/Sports
❑ Sleep
❑ Eating
❑ Walking
❑ Attention/Focus
❑ Daily Routine

PREGNANCY AND BIRTH

During pregnancy, did the mother (Check all that apply):

❑ Use any form of fertility treatment? If so, what treatment: _____
❑ Experience any significant illnesses, difficulties, or trauma? _____
❑ Take any drugs/medications? _____
❑ Smoke or consume alcohol? _____

❑ Home birth ❑ Hospital birth ❑ Vaginal ❑ Caesarean

Was the delivery premature? ❑ No ❑ Yes Weeks _____Weight _____
Approximately how long did labor last? _____
Was labor artificially induced? ❑ No ❑ Yes _____
Was it determined that the child was breech or otherwise mispositioned? ❑ No ❑ Yes _____

Please check which, if any of the following were administered or used during labor and birth:

❑ Epidural ❑ Forceps ❑ Vacuum ❑ Medications _____
❑ Pitocin ❑ Episiotomy ❑ Manual traction of the neck _____

Please check all that apply to the baby's status immediately after birth:

❑ Jaundice ❑ Respiratory problems ❑ Broken bones _____
❑ Feeding problem ❑ Displaced joints ❑ Other conditions _____

APGAR Score _____

Was the baby breastfed? ❑ No ❑ Yes For how long? _____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

❑ Academic pressure ❑ Loss of a loved one ❑ Bullying ❑ Relocation
❑ Lifestyle change ❑ Parents' divorce ❑ Loss of a pet ❑ New sibling

Does your child have difficulty interacting with schoolmates or friends? ❑ Yes ❑ No
Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ❑ Yes ❑ No

CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes into contact with the skin. The following will reveal exposures your child may have experienced.

Have you chosen to vaccinate your child? ❑ No ❑ Yes.
If yes, please check all vaccinations the child has received and at what age they were administered:

❑ DPT_____ ❑ MMR _____ ❑ Other _____
❑ Polio_____ ❑ Chicken Pox_____
❑ Hepatitis _____ ❑ Flu _____

Please describe any and all reactions to vaccine(s)_____

Please check all that apply and give any necessary details:

❑ Child exposed to second hand smoke.
❑ Has taken antibiotics. Explain _____
❑ Currently taking medication. Explain _____
❑ Currently taking supplements. Explain _____
❑ Has allergies. Explain _____
What treatments have you used? _____

PHYSICAL STRESS: INFANCY & CHILDHOOD

Is the reason you are seeking care related to?: ❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑ Other

Please check all that apply to your child and give any necessary details:

❑ Uncoordinated/Accident prone_____
❑ Has been hospitalized. _____
❑ Had a severe trauma. _____
❑ Been in an automobile accident. _____
❑ Has fractured a bone or dislocated a joint. _____
❑ Has/had a chronic illness. _____
❑ Has had surgery. _____

What physical activities does your child participate in? _____

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? ❑ Y ❑ N Name of D.C. _____

Reason _____ How long? _____ Date of last visit _____

Why was care stopped? _____

Have you consulted, or do you regularly consult any of the following providers for your child?

Check all that apply ❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath
❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Other

Reason _____

_____

I hereby authorize payment to be made directly to Nicholl Chiropractic Inc., for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Nicholl Chiropractic Inc. for any and all services that are rendered at this office.

Cancellation Policy
24 hour notice must be given to cancel all scheduled appointments.
Appointments cancelled with less than 24 hour notice will automatically generate a $65 fee.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**