



**CORRECTIVE
CHIROPRACTIC**

PEDIATRIC HISTORY FORM

It is a pleasure to welcome you to our chiropractic practice. To help us serve you better, please complete the following information.

PATIENT INFORMATION

DOB ____/____/____ Age ____ Sex ____ Wgt ____ Hgt ____

First Name _____ Middle Init. ____ Last Name _____

Mother's Name _____ Father's Name _____

Address _____ City _____ State ____

Zip Code _____

Home Phone (____) _____ Cell (____) _____ Work (____) _____

Parent Email _____

Type of Birth : Full Term ____ Home ____ Hospital ____ Birth Center ____
Induced ____ Epidural ____ Vaginal ____ C-Sec ____
Breech ____ Forceps ____ Vacuum Extraction ____
Obstetrician ____ Midwife ____

Birth Traumas: Yes / No If Yes, please explain: _____

Pediatrician / Family Physician M.D. _____

Date of Last Visit _____ Vaccinations _____

Did your child experience adverse reactions to the vaccinations? Yes / No

If Yes, please explain: _____

Is your child involved in a sports program? _____

Any injuries? Yes / No If yes, please list them: _____

Has your child ever suffered from any of the following?

<ul style="list-style-type: none"><input type="checkbox"/> Allergies<input type="checkbox"/> Asthma<input type="checkbox"/> Colds / Flu<input type="checkbox"/> Chronic Ear Infections<input type="checkbox"/> Sinus Trouble<input type="checkbox"/> Headaches<input type="checkbox"/> Dizziness<input type="checkbox"/> Fainting<input type="checkbox"/> Tantrums<input type="checkbox"/> Learning Disorders<input type="checkbox"/> Hyperactivity<input type="checkbox"/> ADD / ADHD<input type="checkbox"/> Emotional Disorders<input type="checkbox"/> Irregular Sleeping Pattern<input type="checkbox"/> Nightmares<input type="checkbox"/> Poor Appetite<input type="checkbox"/> Digestive Problems<input type="checkbox"/> Colic<input type="checkbox"/> Stomachaches<input type="checkbox"/> Diarrhea<input type="checkbox"/> Constipation<input type="checkbox"/> Growing Pains <p>Current Medications _____</p> <p>_____</p>	<ul style="list-style-type: none"><input type="checkbox"/> Heart Trouble<input type="checkbox"/> Neuritis<input type="checkbox"/> Diabetes<input type="checkbox"/> Blood Disorder<input type="checkbox"/> Anemia<input type="checkbox"/> Hypertension<input type="checkbox"/> Convulsions<input type="checkbox"/> Rheumatic Fever<input type="checkbox"/> Orthopedic Problems<input type="checkbox"/> Joint Problems<input type="checkbox"/> Muscle Jerking<input type="checkbox"/> Leg Problems<input type="checkbox"/> Arm Problems<input type="checkbox"/> Neck Problems<input type="checkbox"/> Backaches<input type="checkbox"/> Walking Problems<input type="checkbox"/> Paralysis<input type="checkbox"/> Broken Bones<input type="checkbox"/> Hernia/Ruptures<input type="checkbox"/> Other Problems <p>_____</p> <p>_____</p>
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CONSENT TO TREATMENT OF A MINOR

I hereby authorize:

Dr. Chad Laurence, DC of Corrective Chiropractic to administer chiropractic care as deemed necessary and to be fully responsible for payment of all services rendered.

Date _____

Signature _____
(Parent / Guardian)