CONTINUUM CHIROPRACTIC PEDIATRIC HEALTH HISTORY FORM

Today's Date_____

ABOUT THE CHILD

Name _____ Age _____ Date of Birth _____

Gender ❑ M ❑ F Height _____ Weight _____

Home Address _____City _____ State _____ Zip _____

Names and Ages of Siblings_____

Parent A	Parent B
Name _____	Name _____
Home phone (_____) _____	Home phone (_____) _____
Home phone (_____) _____	Home phone (_____) _____
Employer _____	Employer _____
E-mail _____	E-mail _____

How did you hear about our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

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

_____

_____

_____

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

_____

_____

_____

EXPECTATIONS OF CARE

I would like my child to experience the following benefits from Chiropractic Care:

Check all that apply

❑ Symptomatic relief of pain or discomfort
❑ Correction of the cause of the problem as well as relief of symptoms
❑ Prevention of future problems
❑ Healthier spine and nerve system
❑ Optimal health on all levels
❑ OTHER_____

HEALTH, WELLNESS, AND CHIROPRACTIC CARE

PREGNANCY & BIRTH

During pregnancy, did the mother:
❑ Experience any significant illnesses, difficulties, or trauma? _____
❑ Take any drugs/medications? _____
❑ Smoke or consume alcohol

Where and how was the child delivered (check all that apply):
❑ Home birth ❑ Hospital birth ❑ Birthing Center ❑ Vaginal ❑ Water birth ❑ Caesarean

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

The birth process can be traumatic to a baby's spine and cause interference to the nervous system. Please check which, if any, of the following were administered 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 _____

INFANCY & CHILDHOOD

Was your child breastfed? ❑ No ❑ Yes For how long? _____

At what age was food (other than breast milk or formula) first introduced? _____
What were the first 3-5 foods given to the child?_____
_____

Are there any known food allergies? _____

Have you chosen to vaccinate your child? ❑ No ❑ Yes.
If yes, did you follow the traditional schedule for all vaccines? ❑ No ❑ Yes.

Did your child have any negative reactions to any vaccines? ❑ No ❑ Yes.
If yes, please explain? _____
_____

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? _____

Is the reason you are seeking care related to?: ❑ Auto Accident ❑ 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. _____

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? _____

Do you have a regular pediatrician? ❑ Y ❑ N Name: _____

When was the last visit? _____ Reason:_____

Are you satisfied with your care there? ❑ Y ❑ N

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

Check all that apply ❑ Massage Therapist ❑ Naturopath ❑ Acupuncturist ❑ Homeopath
❑ Mental Health Professional ❑ Occupational or Physical Therapist ❑ Other

Reason _____

_____

_____

HEALTH HISTORY

Indicate C for current and P for past

____ Allergies	____ Bed wetting	____ Cold/Flu
____ Asthma	____ Headaches	____ Digestive issues
____ Colic	____ Respiratory disorder	____ Difficulty sleeping
____ Constipation	____ Joint pain	____ Learning disability
____ Feeding Difficulty	____ Diabetes	____ Difficulty sleeping
____ Ear Infections	____ Eczema	____ Behavioral problems

Details:_____

_____

_____

_____

DEVELOPMENTAL HISTORY

At what age did your child achieve the following milestones?:

Hold head up _____	Crawl _____	Walk unassisted _____
Sit unassisted _____	Stand _____	Talk _____

Did your child have any difficulty reaching any of these milestones? _____

_____

IMPORTANT:

Is there anything not mentioned on this form that you feel is important for us to know about your child's heath?

_____

_____

_____

_____

What activities and/or sports does your child enjoy? _____

_____

What is your child's favorite subject in school? _____

What is your child's favorite book? _____

What are your child's 3 favorite foods? _____

Financial Information

Payment in full is expected on all FIRST VISIT services (whether you have insurance coverage or not.) All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit/Debit Card

Is this an Auto Accident Related Injury? ❑ Yes ❑ No

If **yes**, please provide us with the following information:

Has your child been treated elsewhere? ❑ Yes ❑ No

If **yes**, where? ❑ Emergency Room ❑ Primary Care ❑ Other _____

What services were provided? ❑ MRI ❑X-Rays ❑ Medication ❑ Therapy

❑ Other (details)_____

PLEASE READ AND SIGN

The information I have provided on this case history form is true and accurate to the best of my knowledge. I give Dr. Hayes Modlin and Dr. Thad Modlin permission to render care to my child today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Child's Name: (Printed) _____

Parent or Legal Guardian's Name:

(Printed)_____

Signature _____ Date: _____

Thank you for choosing Continuum Chiropractic.

We look forward to helping you.