BAKER FAMILY CHIROPRACTIC

PEDIATRIC HEALTH DISCOVERY FORM

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name _____ SS# ___ — ___ — ____

Address _____

City _____ State _____ ZIP _____ Home Phone ( ) _____

Birth Date ___ / ___ / ____ Parent's Work Phone: ( ) _____

Sex _____ Weight _____ Height _____ Referred By _____

Names of Parents/Guardians _____

Reason for Consulting Our Office? _____

Other Doctors Seen for This Condition? _____ N _____ Y

Doctors' Names and Prior Treatments _____

_____

Spinal or Postural Concerns _____

Other Health Problems or Concerns _____

Check any of the following conditions your child has suffered from during the past six months:

☐ Ear Infections	☐ Scoliosis	☐ Seizures	☐ Chronic Colds	☐ Headaches
☐ Asthma/Allergies	☐ Digestive Problems	☐ ADHD	☐ Recurring Fevers	☐ Growing/Back Pains
☐ Colic	☐ Bed Wetting	☐ Car Accident	☐ Temper Tantrums	☐ Other _____

Significant family health history or disease: _____

Previous Chiropractor _____

Date of Last Visit ___ / ___ / ____ Reason _____

Name of Pediatrician _____

Date of Last Visit ___ / ___ / ____ Reason _____

Are you satisfied with the care your child received there? _____ N _____ Y

Number of Doses of Antibiotics Your Child Has Taken:

During the Past Six Months _____ Total During His/Her Lifetime _____

Number of Doses of Other Prescription Medications Your Child has Taken:

During the Past Six Months _____ Total During His/Her Lifetime _____ List: _____

Vaccination Reactions or Possible Side Effects _____

Vaccination History _____

PRENATAL HISTORY:

Name of Obstetrician/Midwife _____

Complications During Pregnancy? _____ N _____ Y List _____

Ultrasounds During Pregnancy? _____ N _____ Y Number _____

Medications During Pregnancy/Delivery? _____ N _____ Y List _____

Cigarette/Alcohol Use During Pregnancy _____ N _____ Y

Location of Birth _____ Hospital _____ Birthing Center _____ Home

Birth Intervention: _____ Forceps _____ Vacuum Extraction _____ Normal Vaginal Delivery

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_____ Caesarian Section, Emergency or Planned? _____ Epidural _____ Ptosin

Complications During Delivery? _____ N _____ Y List _____

Genetic Disorders or Disabilities _____ N _____ Y List _____

Birth Weight _____ Birth Length _____ APGAR Scores _____ , _____

Baby Cyanotic? _____ N _____ Y Baby Jaundice? _____ N _____ Y

FEEDING HISTORY:

Breast Fed: _____ N _____ Y How Long _____

Formula Fed: _____ N _____ Y How Long _____ Type _____

Introduced to Solids at _____ Months Cow's Milk at _____ Months

Food/Juice Allergies or Intolerances _____ N _____ Y List _____

DEVELOPMENTAL HISTORY:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor or chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to do the following:

_____ Respond to Sound _____ Cross Crawl

_____ Respond to Visual Stimuli _____ Stand Alone

_____ Hold Head Up _____ Walk Alone

_____ Sit Up

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child? _____ N _____ Y

Is/has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)?

_____ N _____ Y List _____

Has your child ever been involved in a car accident? _____ N _____ Y List _____

Has your child been seen on an emergency basis? _____ N _____ Y List _____

Other traumas not described above? _____ N _____ Y List _____

Prior Surgery _____ N _____ Y List _____

Menarche _____ N _____ Y Age _____

CHILDHOOD DISEASES:

Chicken Pox	N / Y , Age _____	Mumps	N / Y , Age _____
Rubella	N / Y , Age _____	Whooping Cough	N / Y , Age _____
Rubeola	N / Y , Age _____	Other	N / Y , Age _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office

Name of Insurance Company: _____ Policy #: _____

Signature of Parent/Guardian: _____ Printed Name _____ Date _____

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