# CEDAR GROVE FAMILY CHIROPRACTIC
## *Confidential Pediatric Patient Information*

**PLEASE PRINT** **DATE: _____**

**Name: _____Parent/Guardian name(s) _____**

**Address: _____City:_____State:_____Zip:_____**

**Birth Date: _____Age:_____Sex: M☐ F☐ E-Mail address (for Dr. Jeff's newsletter) _____**

**Cell Phone: _____-_____-_____ Home Phone_____-_____-_____ Work Phone_____-_____-_____**

**Who may we thank for referring you or how did you hear of us? _____**

**Who is your primary care physician? _____ Is your child receiving care from any other health professional? ❍Yes ❍ No - If yes, please explain**

## CURRENT HEALTH CONDITIONS

What health conditions(s) bring your child to be evaluated by a Chiropractor?

When did this condition first begin? How did the problem start? ❍Suddenly ❍Gradually ❍ Post-injury

Has your child ever received care for this condition before? ❍Yes ❍No
- If yes please explain:

Is this condition: ❍Getting worse ❍Improving ❍Intermittent ❍Constant ❍Unsure

What makes the problem better? What makes the problem worse?

Please list any drugs/medications/vitamins/herbs/other that your child is taking:

## HEALTH GOALS FOR YOUR CHILD

**Your top three health goals**

1. _____
2. _____
3. _____

What would you like to gain from Chiropractic care?

❍Resolve existing condition

❍Overall Wellness

❍Both

Have you ever visited a Chiropractor? ❍Yes ❍No If yes, what is their name?

What is their specialty? ❍Pain Relief ❍ PT/Rehab ❍Subluxation-based ❍Other

## PREGNANCY & FERTILITY HISTORY Please tell us about your pregnancy

Any fertility issues? ❍Yes ❍No If yes, please explain_____

Did mother smoke? ❍Yes ❍No If yes, how many per week_____

Did mother drink? ❍Yes ❍No If yes, how many per week_____

Did mother exercise? ❍Yes ❍No If yes, please explain_____

Was mother ill? ❍Yes ❍No If yes, please explain_____

Any ultrasounds? ❍Yes ❍No If yes, please explain_____

Please explain any notable episodes of mental or physical stress during pregnancy:

Please explain any concerns or notable remarks about your child's conception or pregnancy:

## LABOR & DELIVERY HISTORY

Child's birth was: ❍Natural vaginal birth ❍ Scheduled C-section ❍ Emergency C-section

Child's birth was: ❍At home ❍ At birthing center ❍ At a hospital ❍Other At how many weeks was child born?

Please check any applicable interventions or complications:

❍Breech ❍Induction ❍Pain meds ❍Epidural ❍Episiotomy ❍Vacuum extraction ❍ Forceps ❍ Other

Please describe any other concerns or notable remarks about your child's labor and/or delivery

Child's birth weight: lbs oz Child's birth height: in. APGAR score at birth: APGAR score after 5 minutes:

## GROWTH & DEVELOPMENT HISTORY

Is/ was your child breastfed? ❍Yes ❍No If yes, how long? Difficulty breastfeeding? ❍Yes ❍No

Did they ever use formula? ❍Yes ❍No If yes, at what age? If yes, what type?

Did/does your child ever suffer from colic, reflux or constipation as an infant? ❍Yes ❍No

-If yes, please explain:

Did/does your child frequently arch their neck/back, feel stiff or bang their head? ❍Yes ❍No

-If yes, please explain:

At what age did your child: Respond to sound_____ Follow an object_____ Hold their head up_____ Vocalize_____ Teethe_____

Sit alone_____ Crawl_____ Walk_____ Begin cow's milk_____ Begin solid foods_____

Please list any food intolerances or allergies, and when they began:

Please list your child's hospitalization and surgical history, including the year:

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year:

Have you chosen to vaccinate your child? ❍No ❍Yes, on a delayed or selective schedule ❍Yes, on schedule

-If yes, please list any vaccination reactions:

Has your child received any antibiotics? ❍Yes ❍No

-If yes, please explain:

Night terrors or difficulty sleeping? ❍Yes ❍No If yes, please explain:

Behavioral, social or emotional issues? ❍Yes ❍No If yes, please explain:

How many hours per day does your child typically spend watching a TV, computer tablet or phone?

How would you describe your child's diet? ❍Mostly whole, organic foods ❍Pretty average ❍High amounts of processed foods

Parent/Guardian signature_____ Date: _____