

Welcome to Chiropractic Arts Center of Austin, P.C.

Pediatric History Form

How did you hear about us? _____

Name: _____ Male / Female Date of Birth: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone #: _____ Race: _____

Mother's / Guardian's Name: _____ Home Phone: _____
Employer's Name: _____ Work Phone: _____ Ext. _____
Cell Phone: _____

Father's / Guardian's Name: _____ Home Phone: _____
Employer's Name: _____ Work Phone: _____ Ext. _____
Cell Phone: _____

Prenatal History:

Obstetrician / Midwife Name: _____ Location: Hospital Birthing Center Home
Number of ultrasounds during pregnancy: _____ Cigarette / Alcohol use during pregnancy? Yes / No
Medication use, including over-the-counter and homeopathic during pregnancy? Yes / No List: _____

Pregnancy Complications? Yes / No List: _____

Delivery Complications? Yes / No List: _____

Birth Interventions: Induced Forceps Vacuum Extraction Cesarean Section - Emergency / Planned

Genetic Disorders Y / N List: _____

APGAR Scores _____ / _____ Birth weight: _____ Birth Length: _____

Development History:

The following stages are important for a child's development and it is during these stages that your child's spine is most vulnerable to stress. All children should routinely be checked for subluxation to maintain and prevent potential problems.

List the age your child was able to:

____ Respond to Sound ____ Sit Up ____ Walk Alone ____ Cross Crawl

____ Respond to Visual Stimuli ____ Hold Head Up ____ Stand Up

Breast Fed: Yes / No How long? _____ Formula Fed: Yes / No How long? _____ Type: _____

Introduced: Solids at _____ mos., Cows Milk at _____ mos. Food allergies or intolerances: Yes / No List: _____

Traumas and Injuries:

According to the National Safety Council, approximately 50% of children fall from high places during the first year of life (bed, changing table, down stairs, etc.). Was this the case with your child? Yes / No

List what and age: _____

Has your child been involved in any contact / high impact type sport(s) (soccer, football, gymnastics, etc.)? Y/N

List: _____

Ever been involved in a car accident, even minor? Yes / No List: _____

Has your child ever been seen on an emergency basis? Yes / No List: _____

Any Fractures / Dislocations? Yes / No List what and age: _____

Has your child ever had a blow to the head? Yes / No List: _____

Other traumas or injuries and age: _____

Continue on other side...

Please check any of the following that may apply to your child:

- | | |
|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Reflux / Excessive Spitting-Up |
| <input type="checkbox"/> Ear Aches / Infections | <input type="checkbox"/> Constipation / Diarrhea |
| <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Irritability / Excessive Crying |
| <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Bed-wetting |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> ADD / ADHD |
| <input type="checkbox"/> Bronchitis / Chest Colds | <input type="checkbox"/> Pain- List: _____ |

List any other health conditions your child may have: _____

Other doctors consulted: _____

Results: _____

Pediatrician: _____ Date of last visit: _____ Reason: _____

List any childhood diseases: _____

Previous Surgery? Yes / No List: _____

List antibiotics taken and age: _____

List other medications, including over-the-counter and homeopathic and age: _____

Any adverse reactions to medication(s)? Y / N What? _____

Vaccinations: _____

Terms of Acceptance

When an individual seeks health care in our office and we accept this individual for such care, it is essential for both to be working toward the same objective. It is important that you understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Chiropractic has only one goal: To eliminate subluxations within the spinal column, which interfere with the expression of the body's innate wisdom.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic methods of correction are gentle, specific adjustments of the spine.

Health: A state of optimal physical, mental, and social wellbeing, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column, which causes the alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any diseases or conditions other than vertebral subluxation. However, if during the course of a chiropractic examination we encounter non-chiropractic or unusual findings, we will advise you of our findings. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate major interference to the body's innate wisdom, by specific chiropractic adjustments to correct vertebral subluxations.

I have read and fully understand the above statements.

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

I understand and agree that health and accident insurance policies are an arrangement between the carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand if I suspend or terminate my child's care at this office, any outstanding fees for professional services will be immediately due and payable. I hereby authorize the doctors at Chiropractic Arts Center of Austin, P.C. and whomever they may designate as their assistants to administer any care to my child, as they deem necessary. I also understand that all individuals have a right to achieve optimal health and no individual will be discriminated against because of race, color, creed, religion, sex, age, sexual preference, national origin, citizenship, marital status, disability, veteran status or any other status or characteristic protected under federal, state, or local laws.

I certify that the above information is true and correct to the best of my knowledge.

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