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Chiropractic Central

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Chiropractic Registration and History – Pediatric Form

Child's Name: **Date:**

Child's Residential Address:

State: **Postcode:**

Postal Address:

Home Phone: **Parent Mobile:** **Parent Work:**

Parent Email:

Medicare Card Number: **Ref No:** **Exp Date:**

Date Of Birth:

Names and Ages Of Any Siblings:

Whom may we thank for referring you?

Health History

Please tick if your child is here for wellness care ☐

Reason for Visit?

Have you received other types of care for your child's condition? **Chiropractic** ☐ **GP** ☐ **Medication** ☐ **Pediatrician** ☐ **Other** ☐

Please name other Doctors that have cared for your child:

Date of last Spinal Examination? (X-Ray?)

*Please **circle** any current condition your child may have and **tick** any conditions your child has had in the past.*

ADD/ADHD	Abnormal gait/limping	Abnormal stools	Autism
Aspergers	Asymmetry at hip	Asthma	Back pain
Balance Issues	Bedwetting	Behavioral Issues	Constipation
Colic	Convulsions	Colds/flu	Constant Crying
Cyanosis	Diarrhea	Depression	Dragging of one leg
Digestive Issues	Difficulties with sleep	Ear aches	Ear Infections
Easily Fatigued	Eyes appear symmetrical	Extremity Pain	Fainting Spells
Headaches	Hip Joint locks/dislocates frequently		Inability to tolerate exercise
Nose Bleeds	Pain with bowel movement	Pain w/exercise	Poor school Performance
Recurring Fevers	Scoliosis	Stomach Pain	Temper Tantrums
Unusual attachment to toys/pets		Unusual smelling urine	Unusually Clingy
Unusual attachment to others	Vomiting	Other	Other

*For infants under 2yrs of age, please **circle** if they have had the following:*

Breast Milk	Cows Milk	Soy Milk	Goats Milk
Rice Milk	Oat Milk	Formula	Formula (soy based)
Fruits or fruit Juices	Medications	Sweets	Solids
Organic Foods	Vegetables/Vegetable Juices	Vitamins	Other

Please List all Vaccinations, what type and at what age:

____

____

____

____

____

Mother's Health During Pregnancy

*Please **circle** if applicable to mother during pregnancy.*

Alcohol Use	Allergies	Antibiotics	Bleeding
Back Pain	Caffeine	Chiropractic Care	Complications
Diagnosed Illness	Gestational Diabetes	Hospitalization	Immunizations
Medications	Physical Injury	Pre-eclampsia (high blood pressure)	
Premature Labor	Prenatal Classes	Prenatal Care	Recreational Drug Use
Severe Bloating/Weight Gain		Vitamins/Supplements	Weight Lose

*Please **circle** if applicable to your Labor and Delivery.*

Caesarian	Complications	Homebirth	Induced Labor
Epidural	Longer than 12hrs	Longer than 20hrs	Premature Delivery
Use of Fetal Monitor	Use of Forceps	Use of Vacuum	Vaginal Birth
Other	Other	Other	Other

*Please **circle or fill out** all that apply to child at birth*

Apgar Score at Birth______	Apgar Score 5min later_____	Birth Weight	Choking
Circumcision	Crying	Duration of Pregnancy	Erythomycin
Feeding by bottle	Feeding by nursing	Hep B Shot	Medications
Jaundice	Pale	Respirator	Sleeping Concerns
Vitamin K	Other	Other	Other

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Injuries/Surgeries

Descriptions

Falls: ______________________

Head Injuries/Whiplash: ______________________

Broken Bones/Dislocations: ______________________

Surgeries: ______________________

Medications/Vitamins/Herbs/Minerals

Medications: ______________________

Vitamins: ______________________

Supplements: ______________________

Trauma History Form

Please List any vehicle accidents:

____

Please list any sports or recreational activities currently undertaken:

____

Please list any slips, strains, falls your child may have had:

____

Are there any other accidents/injures you may not have mentioned yet?

____

What are your ultimate goals for your child in visiting Chiropractic Central?

I hereby authorize the Doctor to perform any necessary diagnostic procedures including X-ray to fully evaluate my child's condition for the presence of vertebral subluxation

Parent Signature: **Date:**

____