



Pediatric History Form

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there's any way we can make you and your family feel more comfortable. Many types of stressors (physical, mental and chemical) can interfere with your child's growing brain, spine and nervous system. 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.

Whom may we thank for referring you to this office? _____ Today's Date: _____

Child's Name: _____ Birth Date: ____-____-____ Age: _____ Male Female

Address: _____ City: _____ State: ____ Zip: _____

Primary Guardian's Contact Information

Guardian's Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Carrier: _____

E-mail Address: _____

Preferred Method of Contact: Email Home Phone Cell Phone

Child's Health History

Current Weight: _____ lbs. Current Height: _____ ft. _____ in.

Reason for pursuing care: Maintenance Improved Health Problem: _____

Check any of the following conditions that currently apply:

<input type="checkbox"/> Ear infections	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Chronic Colds	<input type="checkbox"/> Headaches	<input type="checkbox"/> Allergies
<input type="checkbox"/> Digestive problems	<input type="checkbox"/> ADHD/ADD	<input type="checkbox"/> Recurring Fevers	<input type="checkbox"/> Colic	<input type="checkbox"/> Growing/ back pains
<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Tantrums	<input type="checkbox"/> Seizures	<input type="checkbox"/> Asthma	<input type="checkbox"/> Autism
<input type="checkbox"/> Car accident (Please include when)	<input type="checkbox"/> Other: _____			

Other doctors seen for this condition (Please include doctor's names and prior treatment):

Previous Chiropractic Care? No Yes If yes, name doctor and last visit: _____

Name of Pediatrician and last visit: _____

Are you satisfied with the care your child has received at the pediatrician? No Yes

Number of Doses of antibiotics your child has taken: _____ Past 6 months: _____ Total lifetime: _____

Present prescription drugs/ dosage? _____

Past prescription drugs/ dosage? _____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.) _____

Prenatal History

Name of Obstetrician/ Midwife: _____

Location of birth: Hospital: _____ Birthing Center: _____ Home

Complications during pregnancy/ delivery? No Yes If yes, explain: _____

Ultrasounds during pregnancy? No Yes If yes, how many: _____

Medications taken during pregnancy/ delivery? No Yes: _____

Cigarette/ Alcohol use during pregnancy? No Yes If yes, how often: _____

Birth Intervention (Please check all that apply):

_____ Forceps _____ Vacuum Extraction _____ Caesarian Section

If Caesarian Section, was it: _____ Emergency _____ Planned

Genetic disorders/disabilities? No Yes: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____ - _____

Feeding History

Breast Fed: No Yes How long: _____

Formula Fed: No Yes How long: _____ Type: _____

Introduced to: Solid Foods @ _____ months Cow's milk @ _____ months

Food/ Juice allergies or intolerances: No Yes: _____

Developmental History (to the best of your knowledge)

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

Respond to stimuli: _____ Cross Crawl: _____ Stand alone: _____
Respond to visual stimuli: _____ Hold head up: _____ Walk alone: _____

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)

Did your child have a fall similar to what was described above? No Yes: _____

Have there been any other traumas? No Yes: _____

Has your child been involved in any sports? No Yes: _____

Has your child been seen by a physician on an emergency basis? No Yes: _____

Does your child: Eat healthy food (organic products, etc.) Drink water
 Take probiotics Take vitamins Type: _____
 Exercise: none mild moderate heavy daily

Hobbies/ interests: _____

Guardian name: _____ Signature: _____ Date: _____

We love to have kid's pictures in our office! If you would allow us to have your child's picture in the office, please sign below.

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Revival Chiropractic llc., or anyone authorized by Revival Chiropractic llc., of any and all photographs/videos which were taken of my child, for the purposed of promotional TV, website, social media and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute the property of Revival Chiropractic llc., solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentially, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Revival Chiropractic Inc. to share this information via their website and their Facebook/social media including Twitter and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws).

Guardian name: _____ Signature: _____ Date: _____

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Revival Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Child's Name

Guardian's Name

Guardian or Authorized Person's Signature

____/____/____
Date

Witness Initials:

REGARDING: X-rays/Imaging Studies

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF THE X-RAYS IN OUR FILES. PLEASE NOTE: IF X-RAYS ARE NECESSARY, THEY ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF REVIVAL CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

IF YOUR CHILD IS AN INFANT OR UNDER THE AGE OF 12, IT IS UNLIKELY THEY WILL NEED CHIROPRACTIC POSTURAL X-RAYS. HOWEVER, PLEASE SIGN BELOW FOR FUTURE REFERENCE.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Guardian or Authorized Person's Signature

____/____/____
Date

Witness Initials:

Females Only → please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

The first day of my last menstrual cycle was on _____ - _____ - _____ (Date)

I have been provided with a full explanation of when when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

Guardian or Authorized Person's Signature

____/____/____
Date

Witness Initials: