



**FIRST STEPS**  
chiropractic

## 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 is 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.

Child's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Birth Date:    /    /        Male/Female (Circle one)        Weight:        lbs.        Height:        ft.        in.

Parent/ Guardian Name: \_\_\_\_\_

Phone number: \_\_\_\_\_ Parent/Guardian Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Referred by: \_\_\_\_\_

Reason for pursuing care: \_\_\_\_\_

Family history: \_\_\_\_\_

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"/> Reflux	<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Temper Tantrums
<input type="checkbox"/> Seizures	<input type="checkbox"/> Asthma	<input type="checkbox"/> Car accident (Please include when) _____	

Other 1: \_\_\_\_\_ Other 2: \_\_\_\_\_

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

Previous Chiropractic Care?    Y/N        Last visit:    /    /   

Name of Pediatrician: \_\_\_\_\_ Last visit:    /    /   

Are you satisfied with the care your child has received at the pediatrician?    Y/N

# of Doses of antibiotics your child has taken: Past 6 months \_\_\_\_\_ Total lifetime \_\_\_\_\_



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Present prescription drugs/ dosage? \_\_\_\_\_

Past prescription drugs/ dosage? \_\_\_\_\_

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

## Prenatal History

Name of Obstetrician/ Midwife: \_\_\_\_\_

Complications during pregnancy/ delivery? Y/N Explain: \_\_\_\_\_

Ultrasounds during pregnancy? Y/N How many? \_\_\_\_\_

Medications taken during pregnancy/ delivery? Y/N List: \_\_\_\_\_

Cigarette/ Alcohol use during pregnancy? Y/N

Location of birth (circle one): Hospital Birthing Center Home

Birth Intervention (circle one): Induced Forceps Vacuum Caesarian Section

If Caesarian Section, was it (circle one): Emergency Planned

Genetic disorders/disabilities? Y/N List: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ APGAR Scores: \_\_\_\_\_ - \_\_\_\_\_

## Feeding History

Breast Fed: Y/N How long? \_\_\_\_\_ Formula Fed: Y/N How long? \_\_\_\_\_ Type: \_\_\_\_\_

Introduced to: Solid Foods @ \_\_\_\_\_ months Cow's milk @ \_\_\_\_\_ months

Food/ Juice allergies or intolerances: Y/ N List: \_\_\_\_\_

## 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

\_\_\_\_\_ Sit up      \_\_\_\_\_ Talk



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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?

Y/N Explain: \_\_\_\_\_

Other traumas not described above (bike wipeout, trampoline injury, etc.)?

\_\_\_\_\_

Has your child been involved in any sports? Y/N List: \_\_\_\_\_

Has your child been seen by a physician on an emergency basis? Y/N Explain: \_\_\_\_\_

\_\_\_\_\_

## Lifestyle

(please check all that apply)

Does your child:  eat healthy food (organic products, etc.)  drink water  take probiotics  
 take vitamins Type: \_\_\_\_\_

Exercise:  none  mild  moderate  heavy  daily

Hobbies/ interests: \_\_\_\_\_

\_\_\_\_\_

Is there anything else you would like us to know about your child? \_\_\_\_\_

\_\_\_\_\_

Parent/ Guardian name: \_\_\_\_\_ Signature: \_\_\_\_\_



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 First Steps Chiropractic PLLC, or anyone authorized by First Steps Chiropractic PLLC, 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 First Steps Chiropractic PLLC, 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 First Steps Chiropractic PLLC. 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).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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 FORMEDICAL PATHOLOGY. THE DOCTORS OF REVOLUTION 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 MEDICALADVICE.

**IF YOUR CHILD IS AN INFANT OR UNDER THE AGE OF FIVE, IT IS UNLIKELY THEY WILL NEED CHIROPRACTIC POSTURAL XRAYS. HOWEVER, PLEASE SIGN BELOW FOR FUTURE REFERENCE.**

BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS

CHILDS NAME \_\_\_\_\_ CHILDS AGE \_\_\_\_\_

PARENT/GARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE



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