BORER FAMILY CHIROPRACTIC

PEDIATRIC HEALTH APPLICATION

Patient Name: _____ Date:_____

Names of Parents / Guardians: _____

Address:_____ City: _____

State:_____ Zip:_____ Home Phone:_____

SS #:_____Birth Date: _____ Age:_____ Sex: _____

Weight:_____ Height:_____ Referred By_____

Purpose For Contacting Us? _____

_____

Other Doctors Seen for this Condition: NO YES Doctors' Names:_____

Prior Treatments:_____

Has your child been under Chiropractic Care in the past? NO YES Date of last adjustment:____/_____/_____

Circle any of the Following Conditions Your Child has Suffered from During the Past Six Months:

Ear Infections	Scoliosis	Seizures	Chronic Colds	Headaches
Asthma / Allergies	Digestive Problems	ADHD	Recurring Fevers	Colic
Growing / Back Pains	Bed Wetting	Car Accident	Temper Tantrums	

Other Health Problems? _____

Family History: _____

Number of Doses of Antibiotics Your Child has Taken:

During the Past 6 Months: _____ Total During his / her Lifetime: _____

Vaccination History: _____

Prenatal History:

Name of Obstetrician / Midwife**:** _____

Complications During Pregnancy? NO YES, List: _____

Ultrasounds During Pregnancy? NO YES, Number: _____
Medications During Pregnancy / Delivery? NO YES, List: _____
Cigarette / Alcohol Use During Pregnancy: NO YES

Location of Birth: _____ Hospital _____Birthing Center _____ Home

Birth Intervention: _____ Forceps _____Vacuum Extraction _____ Ceasarian Section (Emergency or Planned?)

Complications During Delivery? NO YES, List: _____

Genetic Disorders or Disabilities: NO YES, List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

Feeding History:

Breast Fed: NO YES, How Long: _____

Formula Fed: NO YES, How Long _____ Type: _____

Introduced to Solids at: _____ Months, Cows' Milk at _____Months

Food / Juice Allergies or Intolerances: NO YES, List: _____

Developmental History:

According to the National Saftey 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, etc.). Was this the case with your child? NO YES

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? NO YES, List: _____

Has Your Child Ever Been Involved in a Car Accident? NO YES, List: _____

Has Your Child Been Seen on an Emergency Basis? NO YES, List: _____

Other Traumas Not Described Above? List: _____

Prior Surgery: NO YES, List: _____

Childhood Diseases:

Chicken Pox N / Y, Age _____ Mumps N / Y, Age _____ Rubella N / Y, Age _____
Rubeola N / Y, Age _____ Whooping Cough N / Y, Age _____ Other_____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this office and its Doctors to administer care to my son / daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: _____ Witnessed: _____ Date ___/___/_____