PEDIATRIC HEALTH FORM

Today's Date: _____ Patient No: _____

PATIENT INFORMATION

Patient Name: _____ Parents/Guardians Name: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female Weight: _____ Height: _____

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

Phone #: _____ Parents Email: _____

Emergency contact: _____ Phone #: _____

*Who referred you to us? _____

Name of insured: _____ Date of birth of insured: _____

HEALTH HISTORY

Have you ever had chiropractic care before? ☐ Yes ☐ No Previous Chiropractor: _____

What is the main reason for bringing your child in today? _____

Does your child have/had any of the following:

☐ Disorted skull ☐ Difficulty latching/sucking ☐ Colic

☐ Difficulty turning head ☐ Abnormal posture-head tilt ☐ Tongue/Lip tied

☐ Toe walker ☐ Sits in a "W"/frog position ☐ Early walker

☐ Appears clumsy ☐ Difficulty with crawling-scoot, creep, army crawl (did not crawl on all fours)

Abnormal bowel movements:

☐ Diarrhea ☐ Constipation ☐ Withholding

Sleep quality:

☐ Good ☐ Fair ☐ Poor

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Heater Chiropractic to provide me with chiropractic care, diagnostic testings, and/or thereapeutic services, in accordance with this state's statutes.

Signature of Parent or Guardian: _____ Date: _____

Staff Signature: _____ Date: _____