



CROSSROADS  
CHIROPRACTIC

6000 Meadowbrook mall CT 3A Clemmons NC 27012 | 336-893-5662

# Pediatric History Form

## Patient information:

Child's Name \_\_\_\_\_ Parent(s)/Guardian Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
Is it okay to text you appointment reminders? Yes \_\_\_ No \_\_\_  
Email \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Gender M \_\_\_ F \_\_\_  
Does your child have insurance coverage? Yes \_\_\_ No \_\_\_  
Have you or your child ever had chiropractic care in the past? \_\_\_\_\_  
If yes, what was the doctor's name: \_\_\_\_\_  
Were you pleased with your care? \_\_\_\_\_  
How did you find out about about office? \_\_\_\_\_  
Who is your family's primary care doctor? \_\_\_\_\_  
Please list any medications your child is taking \_\_\_\_\_  
Please list any vitamins/herbs/supplements your child is taking \_\_\_\_\_  
Please list any allergies your child has \_\_\_\_\_

## Current Health:

What health condition brings your child into our office \_\_\_\_\_  
\_\_\_\_\_  
When did the symptoms first begin? \_\_\_\_\_  
How did the problem start? Suddenly \_\_\_ Gradually \_\_\_ Post-injury \_\_\_  
Is the condition: Getting worse \_\_\_ Improving \_\_\_ Intermittent \_\_\_ Constant \_\_\_ Not Sure \_\_\_  
What makes the problem better? \_\_\_\_\_  
What makes the problem worse? \_\_\_\_\_  
Has your child ever had similar conditions? Yes \_\_\_ No \_\_\_  
If yes, please explain \_\_\_\_\_  
Has your child every been treated for this before? Yes \_\_\_ No \_\_\_  
If yes, please explain \_\_\_\_\_  
Does your child eat well? Yes \_\_\_ No \_\_\_  
Does you child have regular bowel movements? Yes \_\_\_ No \_\_\_  
Has your child ever been check for vertebral subluxation? Yes \_\_\_ No \_\_\_ Don't know \_\_\_

### Health History:

Child's birth was: At home\_\_\_ At a birthing center\_\_\_ At a hospital\_\_\_

My OBGYN/Midwife was\_\_\_\_\_

Child birth was:

Natural vaginal (no medications/interventions) \_\_\_

Natural with interventions\_\_\_\_\_

Induction\_\_ Pain medication\_\_ Epidural\_\_ Episiotomy\_\_ Vacuum extraction\_\_ Forceps\_\_

C-section \_\_

Please list reason for any interventions/complications\_\_\_\_\_

\_\_\_\_\_

Child's birth weight\_\_\_\_\_ Child's birth height\_\_\_\_\_ Child's current weight\_\_\_\_\_ Child's current height\_\_\_\_\_

### Growth and Development:

Was your child alert and responsive within 12 hours of delivery? Yes\_\_\_\_\_ No\_\_\_\_\_

If no, please explain:\_\_\_\_\_

At what age did your child:

Respond to sound\_\_\_ Follow an object\_\_\_ Hold head up\_\_\_. Vocalize\_\_\_

Sit alone\_\_\_ Teethe\_\_\_ Crawl\_\_\_ Walk\_\_\_

Patient hospitalization/surgical history:\_\_\_\_\_

\_\_\_\_\_

Please list any major accidents, falls, or fractures your child had\_\_\_\_\_

\_\_\_\_\_

Is/was your child breastfed? Yes\_\_\_ No\_\_\_ If so, how long?\_\_\_\_\_

Formula introduced at age?\_\_\_\_\_ What kind\_\_\_\_\_

Introduction of cow's milk at age\_\_\_\_\_ Started solids at age\_\_\_\_\_

Please list any food/juice intolerances\_\_\_\_\_

Did mother smoke during pregnancy? Yes\_\_\_ No\_\_\_

Did mother drink alcohol during pregnancy? Yes\_\_\_ No\_\_\_

Any drugs/medications taken during pregnancy (including over the counter)\_\_\_\_\_

\_\_\_\_\_

List any supplements taken during pregnancy\_\_\_\_\_

\_\_\_\_\_

Did you baby have any exposure to ultrasounds? Yes\_\_\_ No\_\_\_

If yes, how many?\_\_\_\_\_

Is your child exposed to any pets in the home? Yes\_\_\_ No\_\_\_

Is your child exposed to any smoke in the home Yes\_\_\_ No\_\_\_

Has your child had any vaccinations? Yes\_\_\_ No\_\_\_

If yes, list which ones and list any reactions\_\_\_\_\_

Has your child had any antibiotics? Yes\_\_\_ No\_\_\_

If yes, list how many times and reasons\_\_\_\_\_

Any difficulty breastfeeding? Yes\_\_\_ No\_\_\_

If yes, please explain \_\_\_\_\_

Any difficulty bonding? Yes\_\_\_ No\_\_\_

If yes, please explain \_\_\_\_\_

Any behavioral problems? Yes\_\_\_ No\_\_\_

If yes, please explain \_\_\_\_\_

Any night terrors, sleepwalking, or difficulty sleeping? Yes\_\_\_ No\_\_\_

If yes, please explain \_\_\_\_\_

Average amount of screen time per day\_\_\_\_\_

### **Chiropractic Basics:**

Do you know what subluxation is? Yes\_\_\_ No\_\_\_

Are you seeking chiropractic for: Optimal health/maintenance\_\_\_ Health problems\_\_\_ Both\_\_\_

What would you like your child to gain from chiropractic care\_\_\_\_\_

Are there any other health concerns or anything else you would like us to know about your child?

\_\_\_\_\_  
\_\_\_\_\_

I understand that I am directly and fully responsible to Crossroads Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

-----  
Parent's / Guardian's signature

-----  
Date

-----  
Dr. Barker | Dr. Green

-----  
Date

#### CONSENT FOR TREATMENT AND CARE OF MINORS

I hereby request, authorize and give consent for necessary or appropriate treatment and care to Dr.Barker and Dr. Green, and whomever he/she may designate as his/her assistant or authorized representative, to administer healthcare without limitation as he/she deems necessary to my dependent minor child in my absence. This consent also extends to include diagnostic imaging, laboratory and other diagnostic test results at the doctor's discretion.

MINOR/CHILD'S NAME:

MINOR/CHILD'S DATE OF BIRTH:

YOUR RELATIONSHIP TO MINOR/CHILD:

PRINTED NAME OF PARENT/GUARDIAN:

PARENT/GUARDIAN ADDRESS & PHONE: