# Pediatric Health History

Please take a moment to fill in the following information as completely as possible. We are here to serve you and encourage you to ask questions. Your participation is vital and will help determine your Child's results. (All information is confidential)

Name: ______________________________ Birthday: ____________
Nickname: ____________________ Height: __________ Weight: __________

***Parent/guardian information***

Name: ______________________________ Relationship ____________
Address: ____________________ City ____________ State __ Zip Code ____
Home Phone: __________ Work Phone: __________ E-mail: ______________
Employer: ________________________________________

## ***Purpose of your visit***

Describe the reason for seeking Chiropractic care: ______________________________
________________________________________
How long has your child experienced this problem? ______________________
What do you think may have caused this problem? ______________________
Is it getting ☐ Better ☐Worse ☐About the same ☐Comes and goes
Other doctors seen for this problem: ______________________
What were the treatments and the results: ______________________
Has your child ever been in a car accident? ☐Yes ☐No Ever had surgery ☐Yes ☐No
Are you content with the overall health of your child ☐Yes ☐No
Has your child ever had any of the following problems?

| | | |
|---|---|---|
| ☐ Ear Infections | ☐ Digestive problems | ☐ Asthma |
| ☐ Vision Problems | ☐ Recurring fever | ☐ Scoliosis |
| ☐ Hearing impairment | ☐ Bronchitis | ☐ Seizures |
| ☐ Sleeping problems | ☐ Upper Respiratory problems | ☐ Chronic colds |
| ☐ Frequent colds | ☐ Colic | ☐ Diarrhea |
| ☐ Hyperactivity | ☐ Headaches | ☐ Sinus Trouble |
| ☐ Attention problems | ☐ Back pain | ☐ Bed wetting |
| ☐ Constipation | ☐ Allergies | ☐ Other ____________ |

Is your child currently taking medication? If yes please list: ______________________
________________________________________
Has your child ever taken antibiotics? Yes No How many doses in the past 6 months ________
Vaccination history ☐DPT ☐MMR ☐Polio ☐Measles ☐Chicken Pox ☐Hepatitis B ☐Other __________
Is your child involved in high impact sports? ☐Yes ☐No List ______________________

**Feeding and developmental history**

Was your child breast-fed? ☐Yes ☐No How Long ____ Formula fed? ☐Yes ☐No How long ___
Introduced solid food at _______months. Cows milk at _______months
Food /juice allergies or intolerance? ☐Yes ☐No List __________
Number of hours of sleep per night _______ Quality of sleep: ☐Good ☐Fair ☐Poor
At what age was your child able to:

Respond to sound _____ Respond to visual stimulus ____ Hold head up ____
Cross Crawl _____ Sit up ____ Stand alone ____ Walk alone ____

**Pre-Natal/ Mothers health history**

Pregnancy history and birth information.

| | | |
|---|---|---|
| Did you take medication? | Yes | No |
| Did you smoke? | Yes | No |
| Did you consume alcohol? | Yes | No |
| Did you experience illness? | Yes | No |
| Was labor induced? | Yes | No |

| | | |
|---|---|---|
| Was a C-section performed? | Yes | No |
| ☐Emergency ☐Planned | | |
| Were forceps used? | Yes | No |
| Was delivery premature? | Yes | No |
| Were ultrasounds performed? | Yes | No |
| How many _____ | | |

**All information is correct to the best of my knowledge.**

**Printed Name:** ________________________________

**Signature:** ________________________________ **Date:** ________________

## Terms of Acceptance

When a person seeks chiropractic care in our office, it is essential for both of us to be working towards the same objective.

Chiropractic has only one goal and it's important to understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral Subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social wellbeing, not merely the absence of infirmity.

**Vertebral Subluxation:** Is a misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of nerve impulses, resulting in a decrease in the body's innate ability to express its maximum health potential.

We do not offer to treat any disease or condition other than **Vertebral Subluxation**. However, if during the course of a chiropractic spinal examination or your daily visits, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. OUR ONLY PRACTICE OBJECTIVE is to determine the presence or absence of **Vertebral Subluxation** and correct it via Specific Chiropractic Adjustments.

I, ________________________________ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis and agree to have Dr. Piekarczyk evaluate and provide chiropractic care for my child.

Signature: ________________________________ Date: ______________