KEYSTONE CHIROPRACTIC
PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS HR#:_____

Today's Date_____/_____/_____

Child's Name_____

Date of Birth_____/_____/_____ Age _____

Birth Height _____ Birth Weight _____ Current Height _____ Current Weight _____

Address_____

City_____State_____Zip_____Phone (Home) _____

Mother's Name_____DOB____/____/____Mother's Mobile _____

Father's Name_____DOB____/____/____Father's Mobile _____

Pediatrician/Family MD_____City/State_____

Last Visit:____/____/____Reason for visit:_____

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____Wellness Check-up _____Injury or Accident _____Other

Please explain: _____

*If your child is experiencing **Pain/Discomfort please identify where and for how long***

_____

_____

1. **When did the** Problem first begin? Date____/___/____ __Unknown __Gradual __Sudden
2. **Ever had** this problem **before**?____No___Yes If yes, when? _____
3. Any **bowel or bladder** problems since this problem began? If yes, describe:

_____

4. Have you seen any **other doctors** for this problem?___No___Yes If yes, who?

_____

5. How long ago?_____Days _____Weeks _____Months _____Years
6. What were the results of past treatment? _____
7. How is this problem **NOW?** ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same

☐ Gradually Worsening ☐ On & Off

8. Please list any **medication taken** for this problem: _____

CHILD'S HISTORY:

9. Related to birth, was it a natural birth ___ C-section_____ vacuum extraction____ other_____

10. Any complications with birth? NO_____ YES_____ Please explain if YES:_____

_____

_____

11. Has your child ever sustained an injury playing organized sports?____No____Yes If yes, please explain:

_____

_____

_____

12. Has your child ever sustained an injury in an auto accident?____No____Yes __If yes, please explain:

_____

_____

13. Has your child had any vaccinations?_____

_____

14. Has your child had any injuries from vaccinations that you are aware of?_____

_____

HAS YOUR CHILD EVER SUFFERED FROM: *Check all that apply*

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Asthma
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Walking Trouble
☐ Scoliosis	☐ Anemia	☐ Colds/Flu	☐ Sleeping Problems
☐ Bed Wetting	☐ Colic	☐ Broken Bones	☐ Fall off swing
☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall from crib	☐ Fall down stairs
☐ Fall off bicycle	☐ Fall from high chair	☐ Fall off slide	
☐ Fall from changing table	☐ Fall off monkey bars	☐ Fall off skateboard/skates	

☐Allergies:_____

☐Other: _____

Does your child take any medications or supplements regularly? Yes___ No____ If yes please list and reason they take: _____

_____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. Payments are to be made directly to Keystone Chiropractic for all services received at this office. We do not take insurance at Keystone Chiropractic. Any fee for service will be discussed prior to a fee being charged.

_____ _____-_____-_____

Patient or Authorized Person's Signature *Date Completed*

_____ _____-_____-_____

Doctor's Signature *Date Form Reviewed*

Informed Consent

REGARDING: Chiropractic Adjustments:

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understand both the objective and the method that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral **subluxation**. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures have happened with some chiropractic adjusting techniques. Keystone Chiropractic uses an adjusting method that is softer than manual adjusting methods due to the utilization of an instrument on the spinal column. Certain adjustments on extremities are manual or hands on. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore I hereby consent to treatment at Keystone Chiropractic on this basis.

_____ _____

Parent or Legal Guardian's Signature Date

_____ _____

Doctor's Signature Date