

Pine Mountain Chiropractic Center

“Where Families Come to Get Healthy & Stay Healthy!”



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Pediatric History Form

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Child's Name: _____ Birth Date: ___/___/___ Age _____

Male / Female (Circle one) Weight: _____ lbs. Height: ___ ft. ___ in.

Phone #: _____ Address: _____ City: _____

State: _____ Zip: _____

Parent/Guardian: _____ Referred by: _____

Purpose for contacting our office?

Other Doctors seen for this condition? Y / N Doctor's names and prior treatments: _____

List other health problems: _____

Family history: _____

Check any of the following conditions that currently apply:

Ear Infections Scoliosis Chronic Colds Headaches Allergies Digestive Problems ADHD/ADD

Recurring Fevers Colic Growing/ Back Pains Bed Wetting

Temper Tantrums Seizures Asthma Car Accident: when? _____

Previous Chiropractic Care? Y / N Last Visit? ___/___/___

Name of Pediatrician: _____ Last Visit? ___/___/___

Are you satisfied with the care your child has received at the pediatrician? Y / N

of doses of antibiotics your child has taken: Past 6 months _____ Total lifetime _____

of doses of other prescription medications your child has taken:

Past 6 months _____ Total lifetime _____ List: _____

Vaccination History: _____

Prenatal History

Name of Obstetrician / midwife: _____

Complications during pregnancy/delivery? Y / N Explain: _____

Ultrasounds during pregnancy? Y / N How many? _____

Medications taken during pregnancy/delivery? Y / N List: _____

Cigarette/ Alcohol use during pregnancy? Y / N

Location of birth (circle one): Hospital Birthing Center Home

Birth Intervention (circle one): Forceps Vacuum Extraction Caesarian Section

If Caesarian Section, was it: _____ Emergency or _____ Planned (check one)

Genetic disorders/disabilities? Y / N List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____ - _____

Please see Side on Reverse

Pediatric History Form Continued

Child's Name: _____ Date: _____

Feeding History

Breast Fed: Y / N How long? _____ Formula Fed: Y / N How long? _____ Type: _____

Introduced to: Solid foods @ _____ Months Cow's milk @ _____ Months

Food/ Juice allergies or intolerances: Y / N List: _____

Developmental History

Your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to stimuli _____ Cross crawl _____ Stand alone

_____ Respond to visual stimuli _____ Hold head up _____ Walk alone

_____ Sit up

According to the National Safety 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).

Did your child have a fall similar to what was described above? Y / N Explain: _____

Has your child been involved in any high impact or contact sports? Y / N List: _____

Has your child been seen by a physician on an emergency basis? Y / N Explain: _____

Other traumas not described above? _____

Lifestyle - please check what applies

Does your child:

eat health food products (organic products, etc.) drink water takes probiotics

take vitamins Type: _____

Exercise: none moderate daily heavy

Hobbies/Interests: _____

Notes: _____

Parent/guardian name (please print): _____

Parent/guardian signature: _____ Date: _____