

Simpson Family Chiropractic- Pediatric Application

Child's Name _____ Date _____

Parent/Guardian Name _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Date of Birth: _____ Age: _____ Sex: M F

Student: Full Time _____ Part Time _____

Name of Insured _____ Insured's Birth date _____

Relationship to patient _____

Name of Pediatrician: _____

Date of Last Visit: ____ / ____ / ____ Reason: _____

Who referred you to our office? _____

Reason for consulting our office:

_____ Relief of symptoms

_____ Correction of a problem

_____ Wellness care for optimizing your personal or family's health

_____ Auto injury? Date _____ Reported? Y N

Health Concern	What have you tried to solve this problem?

Has your child ever been to a chiropractor? Yes No Date of last visit? _____

If yes, what type of care did you receive? (Relief/Correction/Wellness)

Please Circle any below that are a part of your health picture (past or present):

Cancer	Muscular Dystrophy	Convulsions	Digestive Disorder
ADHD	Multiple Sclerosis	Epilepsy/Seizures	Sinus Problems
Tuberculosis	Cerebral Palsy	HIV Positive	Loss of Smell
Scoliosis	Ear Infections	Constipation	Heartburn
Heart Trouble	Concussion	Numbness	Asthma
Diabetes	Headaches	Sleeping Problems	Irritability/Temper
Hepatitis	Dizziness	Menstrual Pain	Cold Sweats
Nervousness	Loss of Balance	Menstrual Irregularity	Depression
Buzzing in ears	Croup/Colic	Fainting	Irritability
Fatigue	Backaches	Mood Swings	Bed Wetting
Chronic Colds	Allergies	Fevers	Tonsillitis
Chicken Pox	Rubella	Mumps	Measles

Prenatal/Birth History:

Name of Obstetrician / Midwife: _____
Complications During Pregnancy ? _____ N _____ Y , List: _____
Ultrasounds During Pregnancy ? _____ N _____ Y, Number: _____
Medications During Pregnancy / Delivery ? _____ N _____ Y , List: _____
Cigarette / Alcohol Use During Pregnancy: _____ N _____ Y
Location of Birth: _____ Hospital _____ Birthing Center _____ Home
Birth Intervention: ___ Forceps ___ Vacuum Extraction ___ C-Section (Emergency or Planned)
Complications During Delivery ? _____ N _____ Y, List: _____
Genetic Disorders or Disabilities: _____ N _____ Y, List: _____
Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

Feeding History:

Breast Fed: _____ N _____ Y, How Long: _____
Formula Fed: _____ N _____ Y, How Long: _____ Type: _____

Medication History:

Number of Doses of Antibiotics Your Child has Taken:
During the Past Six Months: _____ , Total During His/Her Lifetime: _____
Number of Doses of Other Prescription Medications Your Child has taken:
During the Past Six Months: _____ , Total During His/Her Lifetime: _____
List: _____
Vaccination History: _____ Any visible reactions? _____

Developmental History:

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, etc.). Was this the case with your child? _____ N _____ Y
Is/has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.) ? _____ N _____ Y
List: _____

Consent to Treatment of Minor Child:

I hereby authorize Dr. Simpson and/or their staff to examine and/or treat my _____
_____ indicate relationship and first name of child

Parent/Guardian Signature: _____ Date: _____