Rockpoint Upper Cervical Center

Pediatric History Form

Patient Name: ______________________ S.S. #: ______________________

Address: ______________________ City: ______________________

State: ______________ Zip: ______________ Home Phone: ______________________

Birthdate: ______________

Sex: M/F Height: __________ Weight: __________ Referred by: ______________________

Name of Parents/Guardians:

____

Purpose for contacting us?

____

Other Doctors seen for this condition:

____

Other Health Problems?

____

Check any of the following conditions your child has suffered from during the past six months:

- ☐ Ear Infections
- ☐ Asthma/Allergies
- ☐ Colic
- ☐ Scoliosis
- ☐ Digestive Problems
- ☐ Bed Wetting
- ☐ Seizures
- ☐ ADHD/ADD
- ☐ Chronic Colds
- ☐ Recurring Fevers
- ☐ Temper Tantrums
- ☐ Growing Pains
- ☐ Headaches
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Other ______________

Previous Chiropractor:

____

Name of Pediatrician:

____

Number of doses of over the counter drugs your child has taken?
During the past 6 months: ______________ Total during his/her lifetime: ______________
Number of doses of antibiotics your child has taken?
During the past 6 months: ______________ Total during his/her lifetime: ______________
Number of doses of prescription medications your child has taken?
During the past 6 months: ______________ Total during his/her lifetime: ______________
List Medications presently taking:

____

Prenatal History

Complications during pregnancy?

____

Ultrasounds during pregnancy?

____

Medications during pregnancy/delivery?

____

Cigarette/alcohol use during pregnancy?

____

2419 Mullan Rd. Suite A
Missoula, MT 59808
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Location of birth: Hospital/Birthing Center/Home

Birth Intervention: Forceps/ Vacuum Extraction/ Caesarian Section (Emergency / Planned)

Complications during delivery?

____

Genetic disorders or disabilities:

____

Birth Weight: ______________ Birth Length: ______________

Breast fed: Y / N How long: __________ Formula fed: Y / N How long: __________

According to the National Safety Council, approximately 50% of children fall headfirst 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? Y / N
Explain:____

Is/has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.). Y / N

____

Has your child ever been involved in a car accident?

____

Has your child been seen on an emergency basis?

____

Other traumas not described above?

____

Prior surgery?

____

I understand and agree that health and accident policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be checked if Health First Chiropractic extends credit to me and I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and paid unless other arrangements are made. I hereby authorize the doctors at Health First Chiropractic and whomever they may designate as their assistants; to administer treatments as they deem necessary and also authorize the release of any information acquired in the course of examination or treatment. I certify that the about information is true and correct.

Name of Insurance Company: ______________ Policy #: ______________

Guardian Print Name: ______________

Signed: ______________

Date: ____/______/______

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