APPLICATION FOR CARE AT M.Y. Life Health Center

MY Life HEALTH CENTER
Chiropractic - Weight Loss - Massage

Pediatric History Form

Patient Name_____ Name of Parents / Guardians_____

Address _____City _____State _____Zip_____

Mother Phone_____ Father Phone_____ Email Address:_____

Birth Date _____ Sex_____ Weight_____ Height_____ Number of siblings_____

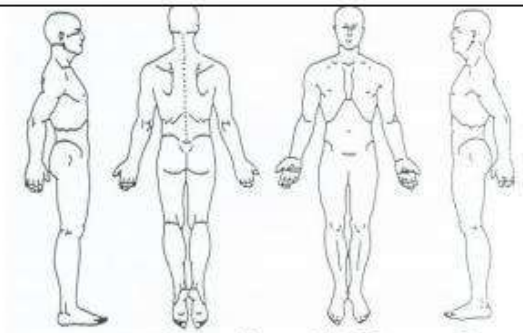
Reason for seeking chiropractic care**:**_____

Other Doctors seen for this condition Y/N Specialty: _____

Prior treatment and outcome: _____

Other Health Problems: _____

Please mark on the body diagram where your child feels the pain and briefly describe their



Please rate your child's pain 0 = No Pain, 10 = Severe Pain

0 1 2 3 4 5 6 7 8 9 10

_____

_____

_____

_____

Medications: Please list any medications your child is taking:

_____

_____

_____

_____

_____

_____

Allergies: Please list any allergies your child has:

_____

_____

_____

_____

_____

Office Notes:

_____

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Symptoms: Please check any current or past problems your child has on the list below:

_Dizziness	_Frequent Colds	_Unusual Moles	_Diarrhea	_Convulsions	_Leg/Hip Pain
_ADHD	_Arthritis	_Neuritis	_Poor Appetite	_Paralysis	_Knee/Foot Pain
_Backaches	_Headaches	_Digestive	_Hyperactivity	_Muscle Pain	_Growing pains
_Heart Condition	_Asthma	_Sinus Trouble	_Behavioral	_Fainting	_Joint Pain
_Chronic Earaches	_Allergies	_Cough/Wheeze	_Poor Memory	_Broken bones	_Scoliosis
_Diabetes	_Runny Nose	_Chest Pain	_Insomnia	_Sprains/Strains	_Blood disorders
_Tuberculosis	_Itchy Eyes	_Constipation	_Nightmares	_Hernias	_Stomach Aches
_Hypertension	_Rashes	_Anemia	_Bed Wetting	_Neck Pain	_Other
_Fever/Chills		_Rheumatic Fever	_Pain Urinating	_Arm/Elbow Pain	

Health History:

Name of Pediatrician: _____ Date of last visit _____

Reason for visit: _____

Has your child been injured participating in contact sports (Soccer, Football, Martial Arts…) Y/N

If yes, describe (Sprain, Broken Bone, Head Trauma…) _____

Has your child ever been involved in a car accident? Y/N Date & Injuries _____

_____

Has your child ever fallen head first from (Changing Table, Bed, Stairs…) Y/N _____

Other traumas not described above? Y/N Type & Date: _____

_____

Prior surgery: Y/N Type and Date:_____

Adverse Reactions to Any Vaccines? Y/N List: _____

Prenatal History (0-5 Year Olds Only)

Location of Birth: O Home O Birthing Center O Hospital O Stepchild O Adopted

Complications during pregnancy: Y/N List: _____

Ultrasounds during pregnancy: Y/N Number: _____

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

Cigarette / Alcohol use during pregnancy: Y/N

Birth intervention: O Forceps O Vacuum O Caesarian, Why?_____

Complications during delivery: Y/N List: _____

Genetic disorders or disabilities: Y/N List: _____

Birth weight_____ Birth length_____

Feeding history (0-5 Year Olds)

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

Type:_____ Introduced to solids at _____ months. Cow's milk at _____ months

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

Developmental History (0-5 Year Olds)

Sleep (Hrs per night) _____ Naps (number & lengths) _____ Problems sleeping _____
At what age was your child able to: Crawl __ Sit alone __ Stand alone __ Walk alone __ Say words __

I understand that I am directly and fully responsible to M.Y. Life Health Center LLC for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

CONSENT TO CHIROPRACTIC CARE

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

I, _____, being the parent or legal guardian of_____ hereby grant permission for my child to receive chiropractic care at M.Y. Life Health Center

Signed _____ Date: _____

Relationship to Child: _____

Witnessed _____ Date _____

Doctor Signature: _____ Date _____

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