Northwest Family
CHIROPRACTIC & MASSAGE

PEDIATRC INFORMATION FORM (BIRTH-12YRS)

Client's Information

Name: _____ Date: _____
Date of birth: _____ Age: _____ Sex: ☐ Male ☐ Female
Parent/Guardian's name(s):_____

What is the primary reason that you are seeking Chiropractic care for your child?

_____
When did it begin? _____
Is it getting worse? Yes/No
What makes it better? _____
What makes it worse? _____
Does it affect their daily activity? ☐ Not at all ☐ Somewhat ☐ Always
Which activities are affected? _____

Prenatal History

Any complications during pregnancy: _____
During pregnancy did the mother:
Use any alcohol? Yes/ No Any tobacco? Yes/No Any vaccines/medication? Yes/No
Reason for vaccines/medications: _____
Illness/infections during pregnancy: _____
Supplements during pregnancy:_____
Ultrasounds or other testing: _____
What things were done to stay healthy during pregnancy?

_____
_____

Birth History

Place of birth: ☐ Home ☐ Birthing Center ☐ Hospital
Provider: ☐ Midwife ☐ OB-Gyn ☐ Other
Type of birth: ☐ Vaginal ☐ Cesareans
Duration of gestation: _____Weeks
Duration of bith:_____
Were pain medications used? Yes/No Pitocin used? Yes/No
Was labor induced? Yes/No If yes, why? _____
Birth trauma? ☐ Doctor assisted ☐ Twisting/Pulling ☐ Vacuum Extraction ☐ Forceps
APGAR score if known: _____
Did your child have a misshaped skull/head? Yes/No
Did your child have any bruising in the skull/face? Yes/No Where?_____

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Growth and Development

Was your infant alert and responsive within twelve hours of delivery? Yes/No
If no, please explain:_____
At what age did your child:
Respond to sound:_____ Follow an object:_____
Hold up head:_____ Vocalize:_____
Begin to teeth:_____ Sit up unassisted:_____
Crawl:_____ Walk: _____

Chemical Stressors

Did you breast-feed your child? Yes/No How long? _____
Was formula introduced? Yes/No At what age? _____
Began solid foods at what age? _____ Type of first food? _____
List any food allergies: _____
Has your child been vaccinated? Yes/No
Reason: ☐ Informed decision ☐ Recommended ☐ Did not know I had a choice
Did your child have any negative reaction to the vaccines? Yes/No
If yes, were they reported? Yes/No
Has your child been on antibiotics? Yes/No
If yes, how often and what purpose? _____
Is your child currently taking any medication? Yes/No
If yes, how often and what purpose? _____
Is your child currently taking any vitamins Yes/No
If yes, please list: _____
How many glasses does your child drink per day? Water _____ Milk _____ Juice _____ Soda _____
Does your child consume artificial sweeteners? Yes/No
Rate your child's diet: ☐ Well-balanced ☐ Average ☐ High sugar/ processed foods
What is your child's favorite food?_____

Client: Please fill out if age 0-4 years

Have any of the following occurred?

Jaundice	Colic	Reflux
Anemia	Frequent Diarrhea	Fall from a changing table
Cyanosis	Constipation	Fall out crib
Seizures	Sleeping problems	Fall off playground
Infections	Frequent fevers	Tumble down stairs
Tonsillitis	Frequent crying spells	Play in Johnny Jumper
Frequent ear infections	Repeated colds	Car accident

Other _____

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Client: Please fill out if age 5-12

Have any of the following occurred?

Fall from a tree	Stomach Pains	Bed-wetting
Fall off a bicycle	Hyperactivity/ Autism	Asthma
Fall on playground	Leg/Knee pains	Allergies
Sports accident	Scoliosis	Growing Pains
Car accident	Learning difficulties	Headaches/ Migraines

Other _____

Does your child participate in any athletic extracurricular activities? Yes/No
If yes, which ones? _____
Number of hours your child sleeps? _____hours/day
Sleep quality? ☐ Good ☐ Fair ☐ Poor

Is there anything else the Doctor should know? _____
_____
Have you, the child's legal guardian, had any personal experience with Chiropractic? Yes/No

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Authorization to Evaluate and care for a Minor

I, _____ the undersigning parent/ guardian having legal custody/ guardianship of _____, a minor, do herby authorize, request, and direct the staff and doctors of Northwest Family Chiropractic & Massage to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Child's name: _____
Parent/ Guardian's signature: _____ Date: _____

Our Mission is to provide a profound health care experience in a professional and genuine environment. We empower our clients through individualized Chiropractic programs and lifestyle coaching and inspire our clients to uncover the natural healing power from within.

Welcome to NW Family Chiropractic & Massage