Lifetime Family CHIROPRACTIC

PEDIATRIC APPLICATION & CASE HISTORY FORM

Welcome to our practice! Please thoroughly complete all questions. Thank you.

Child's Name: ____ Date: ____________________

Father's Name: ______________________________ Mother's Name: ____________________________

Address: ____

City/State/Zip: ____

Home Phone: ____________________ Mother's Cell: ______________________________________

Father's Cell: ______________________________________

Birth date: _____/_____/_____ Age: _________

Who may we thank for referring you? ____

What is your main concern (if any) for your child today? __________________________________

Pediatrician (if any): ____

Natural childbirth? ____Yes ____ No Forceps or vacuum used? ___ Yes ___ No

____ In-home ____ Birth Center ____ Hospital OB or Midwife's name:__________________

Ear Infections___ Yes ___ No Tubes ___ Yes ___ No Colic ___ Yes ___ No

Current Medications: ____

Current or past surgeries: ____

Complications of pregnancy? ____

Complications of delivery? ____

According to the National Safety Council, approximately 50% of infants fall head first from a high place (bed, changing table, etc.) during their first year of life. Has this happened to your child?
___Yes ___No

Additional Falls/Accidents? ____

Learned to crawl _____ months Learned to walk ______months

Who was your prior doctor of chiropractic? ____

Was your child evaluated by a chiropractor within 1 month of life? ___ Yes ___ No

Have you noticed any abnormality with the way your child walks or runs? (Ex: limps, high hip, feet turn in or out)? ____

Other concerns you have? ____

The above information is true and accurate to the best of my knowledge. I authorize evaluation and care (if needed) for my child.

Parent or Guardian Signature:_______________________________________Date:___________