Awakening Chiropractic North PLLC
12 Yeaton RD Unit A1 Plymouth, NH 03264 (603)238-9044

Pediatric History Form

Today's Date: ____/_____/____ Home #___________________ Cell#_______________________

Patient's Name: _________________________________

Parents/Guardian Names: ____

Mailing Address: ____

City/State/Zip Code: ____

Parent's email address (for office announcements):
____

Child's Birth Date: ___/___/___ Age: ____

Who can we thank for referring you to our office?
____

Previous Chiropractic Care? Y N Prior Doctor of Chiropractic: ____________________________

Please check the reasons for pursuing chiropractic care for your child:
___ *I Recently had my spine checked and I see the value in getting my child checked.*
___ *I'm concerned about his/her health and I'm looking for answers.*
___ *She/he has a specific condition that concerns me.*
Explain condition of symptom:
____
___*I want to improve my child's immune function.*
___*I have no idea why we're here. Please take the time to explain to me what you do for children.*

In order for us to better understand your child's current level of health, please check any of the following body signals which your child has or has had previously:
___Headaches ___Postural Imbalance ___Asthma ___Ear Infection
___Scoliosis ___ADD/ADHD ___PDD/Autism ___Seizures
___Growing/Back Pain ___Car Accident ___Digestive Problems ___Colic
___ Frequent Colds ___Sinus Problems ___Bedwetting ___Sleep Disorders

Other:
____

List Prescription or Over the Counter Medications Currently Taking or Previously Taken:
____

*Known Allergies:*____

The number of doses of **Antibiotics** your child has taken:
During the past 6 months: _________
Total during his/her lifetime: ________
List reasons: ____

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What was the date of last **Vaccination** given to your child? ____________________
Pediatric Recommended Schedule ___Yes ___No
Delayed Schedule ___Yes ___No

Prenatal History:

Adopted? ____No ___Yes
Complications during pregnancy? ___No ___Yes
List:
____

Ultrasounds during pregnancy? ___No ___Yes How Many? _______
Medications/drugs/caffeine during pregnancy? ____No ___Yes
List: ____
Cigarette/Alcohol use during pregnancy? N or Y

Location of Birth: ___Hospital ___Birthing Center ___Home

Birth Intervention: ___All Natural/Mother Induced ___Mother Medicated (Pitocin, etc.)
___Caesarean Section ___Forceps ___Vacuum Extracted
___ Baby given medication after delivery: __________________________________
Complications during delivery: ___No ___Yes
Explain:
____

Genetic Disorders or Disabilities? ___No ___Yes List: ______________________________
____
Breast Fed? ___No ___Yes How Long? _______ Formula Fed? ___No ___Yes How Long? _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (I.E., a bed, changing table, down stairs, etc.). Was this the case with your child? ___No ___Yes
Explain: ____

Is/Has your child been involved in any high impact or contact type sports (I.E., soccer, football, gymnastics, hockey, baseball, cheerleading, martial arts, basketball, etc.)? ___No ___Yes
List: ____
Has your child been seen on an Emergency Basis? ___No ___Yes
List:____
Prior Surgery? ___No ___Yes List:
____

It is important that our patients and we have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe that the greatest Doctor is the one already inside each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept for your child, if eligible, chiropractic care on this basis.

____ ___/___/___
Parent/Guardian Signature **Date**

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AUTHORIZATION: The process of determining suitability for Chiropractic Services involves answering fully and truthfully all questions presented to you either written or spoken regarding your past
and present health status. If warranted, a physical examination will be performed that can include but is
not limited to vitals measurement, systems evaluation, orthopedic tests, and maneuvers (tests that move
and stress parts of the body), neurological test (tests using sharp or dull instruments, smells, or sounds,
gently tapping) as well as physical touching. These test and maneuvers will help the Chiropractor determine what may be causing your complaints. Occasionally some temporary soreness and/or stiffness
may occur due to the examination, less frequently aggravation of presenting symptoms or initiation of new symptoms. By signing below, you have authorized the performance of a consultation and examination.

ACKNOWLEDGEMENT: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below, you
have authorized this office to contact you for office related matters and thank you notices for referrals using your first name in the following manner: phone-work-home or mobile, e-mail and regular mail to include sealed envelopes and postcards. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also, in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliging to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your
rights as a patient.

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF:
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.

__________________________ __________________________
Patient Name Printed Date

__________________________ __________________________
Patient Signature Authorized Provider Rep.

__________________________ __________________________
Personal Representative Printed Personal Rep. Signature

Description of personal representative’s authority to act for the patient: