



### Pediatric Patient Information

Name:	Today's Date:	
What patient prefers to be called:		
Parent's/Guardian's Name(s):		
Home Phone: (    )	Parent's Cell: (    )	
Mailing Address:	City/State:	Zip:
Birth Date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Parent's E-mail Address (for newsletters and appointment information):		Social Security #:
How did you learn about our office?		
Recent Auto Accident: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Previous Chiropractic Care: <input type="checkbox"/> Yes <input type="checkbox"/> No	Approximate Last Visit Date:	

**Please check reasons for pursuing chiropractic care for your child:**

- He/she is continuing ongoing care from another chiropractor.
- I recently had my spine checked and see the value in getting my child checked.
- I'm concerned about his/her health and I'm looking for answers.
- He/she has a specific condition that concerns me.

Explain condition or symptom:

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- 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 can offer my child(ren).

**In order for us to better understand your child's current level of health, please check any of the following body signals which he/she has or has had previously:**

- Headaches/Migraines
- Asthma
- Sleep Problems
- Weight Problems
- ADD/ADHD
- Postural Imbalance
- PDD/Autism
- Seizures
- Frequent Colds
- Allergy/Sinus Problems
- Bedwetting
- Ear Infection
- Car Accident
- Colic
- Digestive Problems
- Scoliosis
- Growing/Back Problems

**Number of doses of antibiotics your child has taken:**

During the past 6 months: \_\_\_\_\_

Total during his/her lifetime: \_\_\_\_\_

List reasons: \_\_\_\_\_

**Number of doses of other prescription medications your child has taken:**

During the past 6 months: \_\_\_\_\_

Total during his/her lifetime: \_\_\_\_\_

List reasons: \_\_\_\_\_

**Prenatal History:**

Adopted:  Yes  No

Complications During Pregnancy:  Yes  No

List reasons: \_\_\_\_\_

Ultrasounds During Pregnancy:  Yes  No Number: \_\_\_\_\_

Medications/drugs/caffeine use during pregnancy?  Yes  No

Please list: \_\_\_\_\_

Cigarette/Alcohol use during pregnancy?  Yes  No

Location of birth:  Hospital  Birthing Center  Home

**Birth Intervention:**

Mother Induced  Mother medicated (Pitocin, etc)  Cesarean Section

Forceps  Vacuum Extracted  Baby given medication after delivery

Complications During Delivery:  Yes  No List: \_\_\_\_\_

Genetic Disorders or Disabilities:  Yes  No List: \_\_\_\_\_

Breast Fed?  Yes  No How Long? \_\_\_\_\_ Formula Fed?  Yes  No How Long? \_\_\_\_\_

Food or Other Allergies?  Yes  No List: \_\_\_\_\_

**According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (ex. A bed, changing table, down stairs, etc.). Was this the case with your child?**

Yes  No List: \_\_\_\_\_

**Is/Has your child been involved in any high-impact or contact-type sports (ex. Soccer, football, gymnastics, hockey, basketball, cheerleading, martial arts, etc.)?**

Yes  No List: \_\_\_\_\_

**Has your child been seen in an emergency room?**

Yes  No List: \_\_\_\_\_

**Prior surgery?**

Yes  No List: \_\_\_\_\_

**Notice:**

It is important that our patients and we have the same health objectives regarding 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 innate and internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe the greatest Doctor is the one already inside each of our patients, and we only help to maximize their inherent healing power without the use of drugs or surgery.

**Disclosures:**

- Your signature verifies that the information given in this form is complete and correct and that you accept, if eligible, chiropractic care on this basis.
- I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. Generations Chiropractic does not accept assignment of insurance benefits, but will provide all documentation for me to use in filing claims with my insurance company.
- If my case is accepted by Generations Chiropractic, adjustments will be performed in our adjusting area, where others may be receiving adjustments. I understand and consent to this form of care.
- I consent to have my spouse/significant other present during my report of findings.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

**Please provide a signature for any of the following that apply to you:**

**Consent to evaluation and adjustment of a minor child:**

I \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_  
*Print Name of Consenting Adult* *Print Name of Minor*

have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

\_\_\_\_\_  
*Consenting Adult's Signature*

\_\_\_\_\_  
*Date*

**Pregnancy Release (Females of Child-Bearing Age):**

I certify that to the best of my knowledge my child is not pregnant, and Drs. Denny & Mandy Warren and their associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*