PRO HEALTH
CHIROPRACTIC CENTER, LLC

Name_____ Age___ DOB___/___/____ Sex___ Ht_____ Wt_____
(First) (Middle) (Last)

Name(s) of Parent(s)/Guardian(s)_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Who referred you to our office?_____

PEDIATRIC CHIROPRACTIC CASE HISTORY

Purpose for contacting our office:_____

Other doctors seen for this condition:_____

Other health problems:_____

Check any of the following conditions your child has suffered from:

☐ ADHD	☐ Allergies/Rashes	☐ Asthma	☐ Auto Accident
☐ Bed Wetting	☐ Chronic Colds	☐ Colic	☐ Digestive Problems
☐ Ear Infections	☐ Headaches	☐ Nose Bleeds	☐ Recurring Fevers
☐ Scoliosis	☐ Seizures	☐ Other_____	

Previous Chiropractor:_____ Date of last visit:_____

Name of Pediatrician:_____ Date of last visit:_____

Number of doses of antibiotics your child has taken:

During the past six months:_____ During entire life:_____

Number of doses of medications your child has taken:

During the past six months:_____ During entire life:_____

Vaccination history:_____

Complications during pregnancy: ☐ No ☐ Yes, explain_____

Medication during pregnancy: ☐ No ☐ Yes, how many_____

Alcohol/Cigarette use: ☐ No ☐ Yes, explain_____

Location of delivery: ☐ Hospital ☐ Home ☐ Other_____

Complications during delivery: ☐ No ☐ Yes, explain_____

Birth Intervention: ☐ Caesarian Section ☐ Vacuum Extraction ☐ Spinal Tap ☐ Forceps

Birth Height:_____ Birth Weight:_____ APGAR Scores:_____

Breast Fed: ☐ No ☐ Yes, how long_____ Formula: ☐ No ☐ Yes, how long_____

Introduced to solids at_____ months. Cow's milk at _____ months.

Childhood Disease:

☐ Chicken Pox, age_____ ☐ Rubeola, age_____ ☐ Whooping Cough, age_____

☐ Rubella, age_____ ☐ Mumps, age_____ ☐ Other_____, age_____

At what age was your child able to:

Respond to sound stimuli_____ Hold head up_____ Stand alone_____

Respond to visual stimuli_____ Cross Crawl_____ Walk alone_____

Check all surgeries or procedures that apply: ☐ My child has never had any surgeries or procedures

☐ Vaccinations ☐ Tonsillectomy ☐ Hernia ☐ Other_____

List any medications your child is currently using and reason for use_____

_____

Please provide any other relevant, health-related information_____

_____

CONSENT TO X-RAY- Only if the Doctor recommends it for your child

By my signature below I am acknowledging that I have had the opportunity to discuss any risks associated with exposure to x-rays for my child. After consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my child's case. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

Signature_____ Date_____

Do you have Health Insurance? ☐ No ☐ Yes (same as parent under chiropractic care)

☐ Yes (parent not under care, please fill out the box bellow)

Name of Insured_____ DOB____/____/____ SSN_____-____-_____

Insured's Employer_____ Insured's Phone Number_____

Insurance Company_____ Policy Number_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize PROHealth Chiropractic Center to provide my child with chiropractic care, in accordance with Connecticut's statutes.

Parent / Guardian Signature_____ Date_____