Innate Way
FAMILY CHIROPRACTIC
500 South Davis Street, Suite B, Hamilton, MO 64644 - 816.583.2220 - innateway.com

Pediatric Health History Form

Newborn to 12 years of age

ABOUT THE CHILD

Today's Date _____

Name _____Age _____ Date of Birth _____

Gender ☐ M ☐ F Height_____ Weight _____

Home Address _____City _____State _____ Zip _____

Names and Ages of Siblings_____

Parent A	Parent B
Name _____	Name _____
Phone (_____) _____ Carrier_____	Phone (_____) _____ Carrier_____
Employer _____	Employer _____
E-mail _____	E-mail _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Innate Way Family Chiropractic can address for your child? _____

_____

Related to: ☐ Sports ☐ Auto ☐ Fall ☐ Chronic ☐ Home Injury ☐ Other _____

Please describe how these concerns are affecting your child's quality of life: _____

_____

Check all that apply

☐ School	☐ Exercise/Sports	☐ Walking
☐ Playing	☐ Sleep	☐ Attention/Focus
☐ Communication	☐ Eating	☐ Daily Routine

EXPECTATIONS OF CARE

I would like my child to experience the following benefits from Chiropractic Care:

Check all that apply
- ☐ Symptomatic relief of pain or discomfort
- ☐ Correction of the cause of the problem as well as relief of symptoms
- ☐ Prevention of future problems
- ☐ Healthier spine and nervous system
- ☐ Optimal health on all levels
- ☐ Other_____

PREGNANCY & BIRTH

During pregnancy, did the mother:

☐ Experience any significant illnesses, difficulties, or trauma? _____

☐ Take any drugs/medications? _____

☐ Smoke or consume alcohol? _____

Type of Birth (check all that apply):

☐ Home birth ☐ Hospital birth ☐ Vaginal ☐ Water birth ☐ Caesarean

Was the delivery premature? ☐ No ☐ Yes Weeks _____Weight_____

Approximately how long did labor last? _____ hours

Was labor artificially induced? ☐ No ☐ Yes _____

Was it determined that the child was breech or otherwise mispositioned? ☐ No ☐ Yes _____

The birth process can be traumatic to a baby's spine and cause interference to the nervous system. Please check which, if any, of the following were administered during labor and birth:

☐ Epidural ☐ Forceps ☐ Vacuum ☐ Medications _____

☐ Pitocin ☐ Episiotomy ☐ Manual traction of the neck

Please check all that apply to the baby's status immediately after birth:

☐ Jaundice ☐ Respiratory Problems ☐ Broken Bones _____

☐ Feeding Problem ☐ Displaced Joints ☐ Other Conditions _____

APGAR Score _____

Was/is the baby breastfed? ☐ No ☐ Yes For how long? _____

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? ☐ No ☐ Yes Name of D.C. _____

Reason _____ How long? _____ Date of last visit _____

Why was care stopped? _____

Have you consulted, or do you regularly consult any of the following providers for your child?

Check all that apply ☐ Medical Physician ☐ Naturopath ☐ Acupuncturist ☐ Homeopath

☐ Massage Therapist ☐ Psychotherapist ☐ Other

CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body is breathed, injected, taken by mouth, or encounters the skin.
The following will reveal exposures your child may have experienced.

Have you chosen to vaccinate your child? ☐ No ☐ Yes
If yes, which vaccination schedule are you following? ☐ Standard ☐ Delayed ☐ Other _____
Please describe any and all reactions to vaccine(s) _____

Please check all that apply and give any necessary details:
☐ Child exposed to second hand smoke _____
☐ Has taken antibiotics _____
☐ Currently taking medication _____
☐ Currently taking supplements _____
☐ Has allergies _____
What treatments have you used? _____

PHYSICAL STRESS: INFANCY & CHILDHOOD

Is the reason you are seeking care related to: ☐ Sports ☐ Auto ☐ Fall ☐ Chronic ☐ Home Injury ☐ Other

Please check all that apply to your child and give any necessary details:
☐ Uncoordinated/Accident prone _____
☐ Has been hospitalized _____
☐ Had a severe trauma _____
☐ Been in an automobile accident_____
☐ Has fractured a bone or dislocated a joint_____
☐ Has/had a chronic illness _____
☐ Has had surgery _____

What physical activities does your child participate in? _____

Did your child crawl? ☐ Yes ☐ No How long? _____
Issues/Abnormal patterns? Please explain _____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

☐ Academic pressure	☐ Loss of a loved one	☐ Bullying	☐ Relocation
☐ Lifestyle change	☐ Parents' divorce	☐ Loss of a pet	☐ New sibling

Does your child have difficulty interacting with schoolmates or friends? ☐ Yes ☐ No
Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ☐ Yes ☐ No

PLEASE READ AND SIGN

1. I acknowledge that Innate Way Family Chiropractic has informed me that they are not in network with any insurance providers. Therefore, they cannot guarantee that claims for any services rendered to me by Dr. Sarah Connelly and/or Innate Way Family Chiropractic will be reimbursed.
2. I consent to receive communication from Innate Way via email, postal mail, text and telephone messaging in connection with my care.
   ☐ Yes ☐ No If I should withdraw my consent, I will notify the office in writing.
3. I consent to my name (first name, last initial) being posted on the Referral Board when I refer a new patient to Innate Way.
   ☐ Yes ☐ No If I should withdraw my consent, I will notify the office in writing.

The information I have provided on this case history form is true and accurate to the best of my knowledge.
I give Dr. Sarah Connelly and the staff at Innate Way Family Chiropractic permission to render care to me today.
This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Child's Name (Printed): _____
Signature of Parent (for minor): _____Date: _____

I understand that I am directly and fully responsible to Innate Way Family Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

_____ _____-_____-_____
Patient or Legal Guardian's Signature **Date**

_____ _____-_____-_____
Doctor's Signature **Date**