

## **Affinity Chiropractic Pediatric Welcome Form**

Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Email: \_\_\_\_\_  
Names of Parents/Guardians: \_\_\_\_\_  
Referred by: \_\_\_\_\_

**Reason for today's visit:** \_\_\_\_\_

Have other Doctors been consulted for this? **Y** or **N**

If Yes, please list Doctors and previous treatments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other health problems? \_\_\_\_\_

Check any of the following health conditions you child has suffered from during the past 6 months:

- |                                             |                                        |                                             |
|---------------------------------------------|----------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Ear Infections     | <input type="checkbox"/> Bed wetting   | <input type="checkbox"/> Recurring Fevers   |
| <input type="checkbox"/> Asthma/Allergies   | <input type="checkbox"/> Seizures      | <input type="checkbox"/> Temper Tantrums    |
| <input type="checkbox"/> Colic              | <input type="checkbox"/> ADHD          | <input type="checkbox"/> Headaches          |
| <input type="checkbox"/> Scoliosis          | <input type="checkbox"/> Car Accident  | <input type="checkbox"/> Growing Back Pains |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Other _____        |

Pertinent Family History: \_\_\_\_\_  
\_\_\_\_\_

Previous chiropractor: \_\_\_\_\_

Last Seen: \_\_\_\_\_ Reason: \_\_\_\_\_

Name of Pediatrician: \_\_\_\_\_

Last Seen: \_\_\_\_\_ Reason: \_\_\_\_\_

Are you satisfied with the care of your child there? \_\_\_\_\_

Number of doses of Antibiotics your child has taken:

During the last 6 mos: \_\_\_\_\_ During his/her lifetime: \_\_\_\_\_ List: \_\_\_\_\_  
\_\_\_\_\_

Vaccination History: \_\_\_\_\_

**Prenatal History:**

Name of Obstetrician/Midwife: \_\_\_\_\_

Complications during pregnancy? **Y or N** List: \_\_\_\_\_

Ultrasounds during pregnancy? **Y or N** Number: \_\_\_\_\_

Medications during pregnancy/delivery? **Y or N** List: \_\_\_\_\_

Cigarette/Alcohol use during pregnancy? **Y or N**

Location of birth (circle one):    Home            Birthing Center            Hospital

Delivery: (circle all that apply):            Forceps            Vacuum            Breech

Vaginal            C-section (emergency or planned.)

Complications during delivery? **Y or N** List: \_\_\_\_\_

Genetic Disorders or Disabilities? **Y or N** List: \_\_\_\_\_

Birth weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ APGAR scores: \_\_\_\_\_

**Feeding History:**

- Breast            How long? \_\_\_\_\_

- Formula            How long? \_\_\_\_\_ Type: \_\_\_\_\_

Introduced Solids at \_\_\_\_\_ months and cow's milk at \_\_\_\_\_ months.

Food/Juice Allergies or Intolerances: **Y or N** List: \_\_\_\_\_  
\_\_\_\_\_

**Developmental History:**

During the following times your child’s spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was you child able to:

_____ respond to sound	_____ cross crawl
_____ respond to visual stimuli	_____ stand alone
_____ hold head up	_____ walk alone
_____ sit up	

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

Has your child ever been involved in a car accident? **Y or N** List: \_\_\_\_\_

Has your child even been seen on an emergency basis? **Y or N** List: \_\_\_\_\_

Other traumas not described above: \_\_\_\_\_

Prior Surgery: \_\_\_\_\_

**Childhood Diseases:**

Chicken Pox: **Y or N** Age \_\_\_\_\_

Mumps: **Y or N** Age \_\_\_\_\_

Rubella: **Y or N** Age \_\_\_\_\_

Whooping cough: **Y or N** Age \_\_\_\_\_

Measles: **Y or N** Age \_\_\_\_\_

Other (\_\_\_\_\_): **Y or N** Age \_\_\_\_\_

**Authorization for Care of a Minor**

I hereby authorize this office and it’s doctor(s) to administer care as they so deem necessary to my son/daughter. I clearly understand that I am personally responsible for payment of all fees charged by this office.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_