NEW LIFE FAMILY Chiropractic

Dr. Christina Petersen 100 Phillips Hill Road, New City, NY 10956

(845)517-0520

Welcome!

Pediatric Case History

(under 18 years of age)

Child's Name: _____

Date of Birth _____ Sex: ☐ M ☐ F

Address: _____

_____

Parents' Name: _____

Phone: (home) _____ (work) _____

(cell) _____

Email:_____

The human body is designed to be healthy. The primary system in the body which coordinates health is the nervous system. The healthy function of every cell, every system, every organ is dependent upon the integrity of the nervous system. The bones of the skull and vertebrae of the spine house and protect the central nervous system. From the birth process until the present, events have occurred in your child's life which may have caused interference and damage to this delicate system. Physical, emotional and chemical stresses common to our contemporary lifestyles can result in misalignment and damage to the spinal column. This interference is called the Vertebral Subluxation Complex. This form will help reveal the causes of Vertebral Subluxation which interfere with optimal function of your child's nervous system and therefore impair your child's inborn health potential.

We are here for you and your family and we encourage you to ask questions. Your participation is vital and will help determine your child's care and results.

ASSESSMENT

1. Reason for contacting us? _____

Other doctors seen for this condition? ☐ Yes ☐ No

Doctors' Names and Prior Treatment

_____

2. Check any of the following conditions your child has suffered from during the past six months:

☐ Ear infections ☐ Scoliosis ☐ Seizures ☐ Chronic Colds ☐ Headaches

☐ Asthma/Allergies ☐ Digestive Problems ☐ ADD or ADHD ☐ Recurring Fevers

☐ Growing Pains or Back Pains ☐ Colic ☐ Bed Wetting ☐ Car Accident

☐ Temper Tantrums ☐ Other _____

3. Check any of the following childhood diseases your child has had:

☐ Chicken Pox - Age _____ ☐ Rubella - Age _____ ☐ Rubeola - Age _____

☐ Mumps - Age _____ ☐ Whooping Cough - Age _____ ☐ Other - Age _____

4. What vaccinations has your child received?_____
_____
__

Did your child experience any behavioral, emotional, or physical changes after any vaccination?

☐ Yes ☐ No

Describe:

_____
_____
__
_____
__

Referred by: _____

5.Place of Birth: ☐ Home ☐ Birthing Center ☐ Hospital

Name of Obstetrician/Midwife:

_____

Complications during pregnancy? ☐ Yes ☐ No If yes, list _____

_____

Did you have an ultrasound during this pregnancy? ☐ Yes ☐ No **If yes, how many?** _____

Was labor induced? ☐ Yes ☐ No

Birth Intervention: ☐ Forceps ☐Vacuum Extraction

☐ C-section: _____Emergency or _____Planned

Complications during delivery? ☐ Yes ☐ No

If yes, list: _____

_____

_

Genetic Disorders or Disabilities? ☐ Yes ☐ No

If yes, list: _____

_____

_

Birth Weight: _____ **Birth Length:** _____ **APGAR Scores:** _____

6. Are you breastfeeding/did you breastfeed your child? ☐ Yes ☐No **How long?** _____

Are you using/did you use formula? ☐ Yes ☐No **How long?** _____

If yes, list: _____

_____

_

Introduction to solids at _____months. Introduction to cows milk at _____months.

Food/juice allergies or intolerances? ☐ Yes ☐No

If yes, list: _____

_____

_

7. According to the National Safety Council approximately 50% of infants have fallen onto their heads during their first years of life. Another study reveals ¼ million children are injured in playground activities annually.

Can you recall any such jolts, falls or traumas to your child? ☐ Yes ☐No
If yes, type
_____
_____
__

8. Is/has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ☐ Yes ☐No
If yes, list: _____
_____
_

9. During the following developmental 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. At approximately what age was your child able to:
Respond to sound_____
Cross crawl _____
Stand alone _____
Respond to visual stimuli _____
Sit up _____
Walk alone _____
Hold head up _____

10. Name of pediatrician: _____
Date of last visit: _____
Reason for visit:
_____

Number of doses of antibiotics your child has taken: During the past 6 months _____ Total during lifetime _____

Other prescription medications your child has taken: _____
_____
__

Has your child had any previous surgery or emergency room visits? List
_____
__

---

11. Previous chiropractic care? ☐ Yes ☐No Name of Chiropractor _____
Date of last visit: _____ Reason: _____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Parent Signature: _____
Date: _____