POJERO FAMILY CHIROPRACTIC

153 Main St, Sayville, NY 11782
(631) 244-0300

Child Health History Form

We are happy you have chosen to have your child's spine checked! Many types of stresses (physical, mental, and chemical) can interfere with your child's growing spine and nervous system. Spinal health is an exciting new concept for many people, so PLEASE ask questions.

Child's Name _____ Date of Birth _____ Age _____

Address _____ City/State/Zip _____

Social Security # _____

Home Phone # _____ Parents Work Phone _____

Mothers Name _____ Fathers Name_____

Names & Ages of Siblings _____

Reason for consulting our office _____

Referred By _____

Previous Chiropractic Care?
Y or N With Whom _____ How long was care received? _____
Reason for stopping care _____

CIRCLE APPROPRIATELY:
Birth Place: Home / Birth Center / Hospital
Type: Vaginal / C-Section
Procedures: Forceps / Vacuum Extraction
Was Delivery Long? Y or N Was Delivery Difficult? Y or N Labor Induced? Y or N
Epidural? Y or N Pain Medication? Y or N Was Baby Breech/In Utero-Constraint? Y or N
Was Baby Breast Feed? Y or N Duration _____

CIRCLE APPROPIATELY:
Which sports does/did your child participate in:
Soccer/Football/Gymnastics/Cheerleading/Karate/Basketball/Dance/Other _____

According to the National Safety Council, approximately 54% of infants fall head first from a high place (bed, changing table, ect.) during their first year of life. Has this happened to your child? Y or N
Comments:_____

List any other falls or accidents _____

OVER

Check any of the following your child has suffered from:

___ Ear Infections	___ Scoliosis	___ Seizures
___ Chronic Colds	___ Asthma/Allergies	___ Digestive Problems
___ Headaches	___ A.D.D./A.D.H.D	___ Recurring Fevers
___ Growing/Back Pains	___ Colic	___ Bed Wetting
___ Constipation	___ Head Banging	___ Other _____

List date and year of any surgeries or hospitalizations: _____

_____

MEDICATIONS

How many rounds of antibiotics has your child taken in the last 6 months? _____Lifetime_____
Present prescription drugs _____
Past prescription drugs _____
Over-the-counter drugs (Tylenol, cough syrup, laxatives, ect.)_____

FINANCIAL INFORMATION

Who is responsible for this account? _____ Relationship _____
Date of Birth _____ SS# _____ Employer _____
What method of payment will you be using ? Insurance Cash Check Other
Name of Insurance Company _____ Policy # _____

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AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize _____ and whomever they may designate to administer care as they deem necessary to my son/daughter _____.

Signed: _____ Witnessed: _____
Dated this _____ day of _____, 200 _____.

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