BELANGER CHIROPRACTIC LIFE CENTER

Specializing in Atlas Orthogonal Chiropractic Sheila E. Belanger, D.C.

1003 East Freeway Dr. SE Conyers, GA 30094

Phone 770-760-1394 Fax 770-760-8414

PEDIATRIC PATIENT HISTORY FORM **(PLEASE PRINT)**

Dear New Patient,
It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Minor Child's Name ______________________________ Date of Birth ____________________

Name of Parents / Guardians ______________________________ Phone ____________________

Referred By: ____

Purpose for contacting us?____

Other doctors seen for this condition: □ YES □ NO If yes, doctors' names and prior treatments:____________________

____

Other health problems?____

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	□ ADHD / ADD	□ Recurring Fevers	□ Growing / Back Pains
□ Colic	□ Bedwetting	□ Car accident	□ Temper Tantrums	□ Other:__________

Family History:____

Previous Chiropractic care: □ NO □ YES, Chiropractor name:______________________________

Date of last visit: ______/______/______ Reason:______________________________

Name of Pediatrician:____

Date of last visit: ______/______/______ Reason:______________________________

Are you satisfied with the care your child has received there? □ YES □ NO

Number of doses of **Antibiotics** your child has taken:

During the past Six Months:_______ Total during his / her lifetime:_________

Number of doses of **Other Prescription Medications** your child has taken:

During the past Six Months:_______ Total during his / her lifetime:_________ List:____________________

Vaccination History □ All □ Some □ None:______________________________

Prenatal History:

Name of Obstetrician / Midwife:____

Complications during pregnancy? □ NO □ YES, List:______________________________

Ultrasounds during pregnancy? □ NO □ YES, Number:_____________

Medications during pregnancy / delivery? □ NO □ YES, List:______________________________

Cigarette / Alcohol use during pregnancy? □ NO □ YES

Location of birth: □ Hospital □ Birthing Center □ Home

Birth intervention: □ Forceps □ Vacuum Extraction □ Caesarian: Emergency or Planned?

Complications during delivery? □ NO □ YES, List:______________________________

Genetic disorders or disabilities? □ NO □ YES, List:______________________________

Birth Weight:________________ Birth Length:________________ APGAR Scores: ___________________ , ___________________

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Feeding History:
Breast fed? □ NO □ YES, How Long:____________________

Formula fed? □ NO □ YES, How Long:____________________ Type:______________________________

Introduced to solids at:______________ months, Cow's milk at:______________ months

Food / Juice Allergies or Intolerance? □ NO □ YES, 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 your child able to:*

Respond to Sound:________________________
Respond to Visual Stimuli:________________________
Hold Head Up:____________________
Sit Up:____________________
Cross Crawl:______________________
Stand Alone:______________________
Walk Alone:______________________

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., a bed, changing table, down stairs, etc). *Was this the case with your child?* □ NO □ YES

Is / has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? □ NO □ YES, List:______________________________

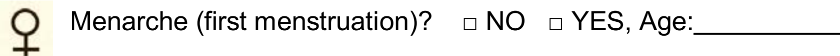
____

Has your child ever been involved in a car accident? □ NO □ YES, List:______________________________

Has your child been seen on an emergency basis? □ NO □ YES, List:______________________________

Other traumas not described above? □ NO □ YES, List:______________________________

Prior surgery? □ NO □ YES, List:______________________________


♀ Menarche (first menstruation)? □ NO □ YES, Age:__________

Childhood Diseases:
Chicken Pox? □ NO □ YES, Age:__________
German Measles / Rubella? □ NO □ YES, Age:____________
Whooping Cough? □ NO □ YES, Age:____________
Mumps? □ NO □ YES, Age:________
Measles / Rubeola? □ NO □ YES, Age:____________
Other:____________________________, Age:________

WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

CONSENT TO TREAT A MINOR: *I hearby authorize the doctor(s) at* ***Belanger Chiropractic Life Center*** *and whomever they designate as assistants to administer chiropractic care to my:* □ son □ daughter □ grandson □ granddaughter □ ____________________

Name of Minor Child (PLEASE PRINT)**:**____

Name of Minor Child's Parent / Guardian / Responsible Party (PLEASE PRINT)**:**______________________________

Signed:____ **Dated:**____________________