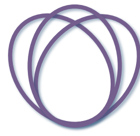

abundance
CHIROPRACTIC

Liz Biehl, DC / 16 Elliott Street, Beverly, MA 01915
www.abundancechiro.com / 978-921-2225

CHILD HISTORY FORM

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.

Patient Name ____

Names of Parents/ Guardians ____

Address____________________________ City ______________________ State________ Zip ___________

Preferred Tel ________________________ Parent Work Tel ________________________

Email ____

Patient Date of Birth _______________ Sex M / F Height ______ Weight ______ # of Siblings ______

How did you hear about our office? ________________________

Reason for seeking chiropractic care:

____

Have you seen other doctors for this condition? Yes / No

If yes, doctors names and prior treatment ____

Other health problems ____

Has your child ever suffered from (check all that apply)

- ❑ Dizziness
- ❑ Diabetes
- ❑ Arthritis
- ❑ Autism / Asperger's
- ❑ Anemia
- ❑ Poor Appetite
- ❑ Bed Wetting
- ❑ Fainting
- ❑ Neck Problems
- ❑ Sensory Problems
- ❑ Backaches
- ❑ Tuberculosis
- ❑ Headaches
- ❑ Digestive Problems
- ❑ Reflux
- ❑ Hyperactivity
- ❑ Seizures
- ❑ Walking Problems
- ❑ Arm Problems
- ❑ Blood Disorders
- ❑ Heart Trouble
- ❑ Hypertension
- ❑ Asthma
- ❑ Sinus Trouble
- ❑ Orthopedic Problems
- ❑ Paralysis
- ❑ Broken Bones
- ❑ Leg Problems
- ❑ Colic
- ❑ Stomach Aches
- ❑ Ear Infections
- ❑ Frequent Colds/ Flu
- ❑ Allergies
- ❑ Constipation
- ❑ Diarrhea
- ❑ Behavioral Problems
- ❑ Muscle Jerking
- ❑ Ruptures/ Hernias
- ❑ "Growing Pains"
- ❑ Other _____________

Family Health History: ____

Previous Chiropractor(s): ________________________ Practice Name:________________________

Reason for Care: ____

Are you satisfied with the care your child received there? Yes / No

Name of Pediatrician: ________________________Practice Name:________________________

Are you satisfied with the care your child received there? Yes / No

Number of antibiotics you child has taken:

During the past 6 months ________ Total during his/her lifetime ________

Number of doses of other prescription medications your child has taken:

During the past 6 months ________ Total during his/her lifetime ________

Vaccination History: Fully vaccinated / Delayed Schedule / Not vaccinated

PRENATAL HISTORY

Type of Birth Attendant: OB / GYN / Midwife Name ____________________

Location of Birth: Home / Birthing Center / Hospital

Complications during pregnancy: Yes / No List: ____________________

Ultrasound during pregnancy: Yes / No Number ________

Medications during pregnancy/ delivery: Yes / No List: ____________________

Cigarette/ Alcohol use during pregnancy: Yes / No

Birth Intervention: Forceps / Vacuum / Caesarian Planned or Emergency? ____________________

Complications during delivery: Yes / No List: ____________________

Genetic disorders or disabilities: Yes / No List: ____________________

Birth weight: ____________ Birth length: ____________ APGAR scores: ____________________

FEEDING HISTORY

Breast Fed: Yes / No How long? ____________

Formula Fed: Yes / No How long? ____________ Type ____________________

Introduced to solids at ________ months; Cow's milk at ________ months

Food allergies or intolerances: Yes / No List ____________________

DEVELOPMENTAL HISTORY

Number of hours sleeping per night ________ Quality of sleep: Good / Fair / Poor

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? Yes / No

Is/has your child been involved in any high impact or contact type sport? Yes / No

Has your child ever been involved in a car accident? Yes / No

Other traumas not described above: Yes / No Date ____________________

Prior surgery: Yes / No Type and Date: ____________________

CHILDHOOD DISEASES

Chicken Pox Y / N Age ________

Rubella Y / N Age ________

Roseola Y / N Age ________

Mumps Y / N Age ________

Whooping Cough Y / N Age ________

Other ____________________

HEALTH INSURANCE

Health Insurance Company Name ____________________

Policy Number ____________________

Policy Holder's Name ____________________

Policy Holder's DOB ____

Relationship to patient ____

**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

I hereby authorize Dr. Liz Biehl of Abundance Chiropractic to administer care to my Son / Daughter as she deems necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Parent / Guardian (Sign) ___________________________________

Parent / Guardian (Print) ___________________________________

Relationship to patient________________________

Today's Date ______________________________