ARC OF LIFE CHIROPRACTIC, LLC
Restoring Function, Maximizing Health, Changing Lives!

Pediatric Application

(birth to 12 years old)

Today's Date: ___/____/_____
Child's Full Name: _____ Date of Birth: ___/____/_____
Parent's/Guardian's Names:_____ Relation To Child:_____
Address: _____ City: _____ Zip Code: _____
Phone: (Home)_____ (Cell)_____ Email:_____

Has your child ever been checked by a Doctor of Chiropractic? ❑ Yes ❑ No
If yes, who? _____ Were X-Rays taken? ❑ Yes ❑ No

Prenatal History

- Is your child adopted? ❑ Yes ❑ No
- Did you take any medications? ❑ Yes ❑ No
- Did you consume alcohol? ❑ Yes ❑ No
- Did you smoke? ❑ Yes ❑ No
- Did you have any complications and when? ❑ Yes ❑ No, Explain:_____
- Did you have an ultrasound during this pregnancy? ❑ Yes ❑ No, How often? _____

Birth History

- Birthing place: ❑ Home ❑ Birthing Center ❑ Hospital
- Provider: ❑ Midwife ❑ OB-Gyn ❑ Other:_____
- What position did you deliver in: ❑ Squatting ❑ On Back Other: _____
- Type of birth: ❑ Vaginal ❑ C-Section
- Was your labor induced? ❑ Yes ❑ No
- Any medications used? ❑ Yes ❑ No Type: _____
- Birth Trauma: ❑ Doctor Assisted ❑ Twisting and/or pulling ❑ Vacuum Extraction ❑ Forceps
- Newborn trauma (medical procedures and tests): _____
- APGAR score: At birth _____ /10 ; at 5-minutes:_____ /10 ; ❑ Unsure
- Did your child have a misshaped skull/ head? ❑ Yes ❑ No
- Purple markings on their face/ head? ❑ Yes ❑ No

- Do you/did you breastfeed your child? ❑ Yes ❑ No, If yes, for how long?_____
- Does your child prefer one breast/side over the other? ❑ Yes ❑ No, If yes, ❑ Right or ❑Left
- Does your child have any food or other allergies? List: _____

- Has your child been immunized according to the recommended schedule? ❑ Yes ❑ No
- Reason for vaccination: ❑ Informed decision ❑ Didn't know I had a choice ❑ Recommended
- Did your child have any negative reactions to vaccinations? ❑ Yes ❑ No, Were they reported? ❑ Yes ❑ No
- Has your child ever had any surgeries? ❑ Yes ❑ No, Please explain: _____
- Have they ever been on antibiotics? ❑ Yes ❑ No, How many rounds? ____ Reasons: _____
- Is your child currently taking any meds? ❑ Yes ❑ No Type: _____
- Number of rounds of *other* prescription medications your child has taken: _____Reason: _____
- Is your child currently taking any vitamins? ❑ Yes ❑ No Type: _____

Baby/Toddler (0-4): Have/Did any of the following occur?

❑ Fall from a changing table	❑ Tonsillitis	❑ Frequent ear infections	❑ Reaction to Vaccines
❑ Repeated infections/colds	❑ Constipation	❑ Frequent fevers	❑ Fall down stairs
❑ Fall off of playground unit	❑ Sleeping Problems	❑ Involvement in MVA	❑ Colic
❑ Play in a Johnny jumper	❑ Fall out of crib	❑ Inadequate weight gain	❑ Frequent diarrhea
❑ Other: _____	Explain:_____		

Child (5-12): Have/Did any of the following occur?

❑ Fall from a tree	❑ Car Accident	❑ Allergies / Asthma	❑ Leg/Knee pain
❑ Fall off a bicycle	❑ Sports Accident	❑ Hyperactivity/Autism	❑ Bed Wetting
❑ Fall off of playground unit	❑ Scoliosis	❑ Learning difficulties	❑ Stomach pains
❑ Other: _____	Explain:_____		

- Which of the above bothers your child the most? _____ Is it getting worse? ❑ Yes ❑ No
- When did it begin? _____ How often does the pain/issue occur? ❑ Constant ❑ Intermit ❑ Cyclic
- How much does the complaint affect daily activities/routines? ❑ None ❑ Somewhat ❑ Frequent ❑ Always

Please check any sports that your child plays:

❑ Soccer	❑ Football	❑ Gymnastics	❑ Karate	❑ Hockey
❑ Lacrosse	❑ Basketball	❑ Dance	❑ Wrestling	❑ Baseball/Softball
❑ Volleyball	❑ Swimming	❑ Tennis	❑ Rugby	❑ Other:_____

- How would you rate your child's diet? ❑ Well balanced ❑ Average ❑ High amounts of sugar and processed food
- Does your child consume: Artificial sweeteners? ❑ Yes ❑ No or Fluoridated water? ❑ Yes ❑ No
- Number of hours your child sleeps? ____/day(nap) and ____/night

Is there anything else we should know about your child? _____
_____
_____

Authorization to Treat a Minor

I, _____, am the undersigning parent/person having legal custody/guardianship whomever s/he may designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment, which is deemed necessary.

Any specific written authorization you provide may be revoked at any time by writing to us as the address provided at the end of this notice.

Name of Patient: (please print) _____ Date of birth _____

Name of Parent/Guardian: (please print)_____

Signature of Parent/Guardian: _____ Today's Date _____

Insurance Information

Insurer's Name: _____ Date of Birth: ___/____/_____ Relation To Child:_____

Insurance Card (to be photocopied below):