Welcome to LaBo Family Chiropractic

Your health potential lies within…. Our Purpose is to set it in motion…………..

Pediatric History form (13 and under)

It is our 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 serve you better, please complete the following information. We look forward to working with you! Thank you!

Date:___________________ Referred By:______________________________

Patient Name:________________________________ Phone Number:________________________

Address: _________________________ City: __________________ State: ____ Zip: ___________

Birth Date:______________ Sex: ____ Weight: ________ Height:____ S.S.#:_________________

Names of Parents/ Guardians: ____

Purpose for contacting us? ____

Other doctors seen for this condition: N/Y If yes, list doctor's name and prior treatments:
____

Other health problems? ____

Research shows that spinal misalignments occur in **8 out of every 10 children** due to the birth process (C-section, Forceps, Vacuum extraction, Vaginal delivery) These misalignments often cause allergies, ear infections, breathing problems and difficulty in concentration.

Poor posture leads to **poor health** and often indicates a spinal problem. How would you rate your child's posture? **Poor** - 1 2 3 4 5 6 7 8 9 10 - **Excellent**

Is your child involved in sports? Y/N If yes, please list:_____________________________
Previous chiropractor: ___________________ Date of last visit:__________ Reason: __________

Were you satisfied: _____________ Why? ____

Name of pediatrician:__________________ Date of last visit:___________ Reason: ___________

Number of doses of antibiotics your child has taken:

a) During the past six months: ____

b) Total during his/ her life: ____

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

a) During the past six months: ____

b) Total during his/ her life: ____

Vaccination history: ____

Prenatal History:

Complications during pregnancy? N/Y If yes, please list them: ________________

Ultrasounds during pregnancy? N/Y If yes, how many: ____________________

Medications during pregnancy/ Delivery? N/Y If yes, please list them: ________________

Cigarette/ alcohol use during pregnancy? N/Y

Location of birth: Hospital: _____ Home: _____ Other: _________________________________

Birth intervention: Forceps: _____ Vacuum Extraction: _____ Caesarian Section: _____

Complications during delivery? N/Y If yes, please list them: _________________________

Regarding your relationship with your child:

Do you miss work often due to your child's illnesses? N/Y

Do you often worry about your child's health? N/Y

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

- ☐ ADD/ADHD
- ☐ Allergies to _________
- ☐ Anemia
- ☐ Arm problems
- ☐ Asthma
- ☐ Auto accident
- ☐ Backaches
- ☐ Bed wetting
- ☐ Behavioral problems
- ☐ Broken bones
- ☐ Car accident ________
- ☐ Chicken Pox
- ☐ Chronic earaches
- ☐ Colds/Flu
- ☐ Colic
- ☐ Diarrhea/Constipation
- ☐ Digestive disorders
- ☐ Dizziness/ Vertigo
- ☐ Ear infections
- ☐ Excessive thirst/appetite
- ☐ Fainting
- ☐ Fall from high place
- ☐ Fall down stairs
- ☐ Fatigue/Weakness
- ☐ Growing pains
- ☐ Headaches
- ☐ Heart Trouble
- ☐ Hypertension
- ☐ Irritability/Mood swings
- ☐ Joint problems
- ☐ Leg problems
- ☐ Mumps
- ☐ Muscle Pains
- ☐ Neck problems
- ☐ Poor appetite
- ☐ Poor Posture
- ☐ Orthopedic problems
- ☐ Recurring fevers
- ☐ Reflux
- ☐ Rubella
- ☐ Rubeola
- ☐ Ruptures/Hernia
- ☐ Scoliosis
- ☐ Seizures/Convulsions
- ☐ Sinus trouble
- ☐ Sleeping problems
- ☐ Stomach aches
- ☐ Temper tantrums
- ☐ Walking trouble
- ☐ Whooping cough
- ☐ Other

CONSENT FOR CARE:

I hereby authorize Dr. Heidi LaBo to administer care to my son/ daughter. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signature:____ Relationship to patient:_________