Swan Lake Chiropractic
724 Pearl Street, Boulder, CO 80302 | 303.449.3103 | swanlakechiro.com

Confidential Pediatric Patient Case History

Date of Birth: _____ Age: _____

□ Male □ Female No. of Siblings: _____

Birth Length _____ Current Length: _____

Birth Weight: _____ Current Weight: _____

Child's Name: _____

Parents Names: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Cell: _____

Home Phone: _____ Work Phone: _____ Referred By: _____

Problems during pregnancy: _____

Problems during labor/delivery: _____

Congenital anomalies/Defects? _____

Number of hours sleeping per night: _____ Quality of Sleep: □ Good □Fair □Poor

Pediatrician/Family MD: _____
Immunization History:_____
Number of doses of Antibiotics your child has taken: In the Past 6 Months _____ During his/her lifetime _____
Previous Chiropractor: _____ Last Adjustment _____
Purpose this of Visit: _____
Has your child ever been treated on an emergency basis: □ Yes □ No – If yes, explain: _____
_____

Delivery/Birth History: _____

_____

_____

_____

General Consent Form: I hereby authorize this office and its doctors to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian).
Financial Awareness and Consent: I understand that I am financially responsible for all charges incurred by me, whether or not my insurance company pays. I hereby assign my insurance benefits to Swan Lake Chiropractic Health Centre. I also authorize any protected heath information required to secure payment.

Printed Name: _____ Date: _____

Responsible Party's Signature, since patient is a minor: _____

Please check off ALL that apply to your child:

__Headaches
__Dizziness
__Fainting
__Seizures/Convulsions
__Heart Trouble
__Chronic Earaches
__Sinus Trouble
__Asthma
__Colds/Flu
__Colic
__Orthopedic Problems
__Neck Problems
__Arm Problems
__Leg Problems
__Joint Problems
__Backaches
__Direct head trauma
__Poor Posture
__Scoliosis
__Walking Trouble
__Broken Bones
__Digestive disorders
__Poor Appetite
__Stomach Aches
__Reflux
__Constipation
__Diarrhea
__Diabetes
__Hypertension
__Anemia
__Bed Wetting
__ Behavioral Problems
__ADD/ADHD
__Ruptures/Hernia
__Muscle Pain
__Growing Pains
__Allergies

Has this child ever suffered the following spinal traumas?

__ Fall in Baby Walker
__ Fall from Crib
__ Fall from Highchair
__ Fall from Changing table
__ Fall from Bed or Couch
__ Fall off Swing
__ Fall off Slide
__ Fall off Monkey Bars
__ Fall off skateboard or skates
__ Fall off bicycle
__ Fall Down Stairs
__ Other _____

Has this child ever sustained an injury playing organized sports? □ Yes □ No – If yes, explain: _____

_____

Has this child ever sustained injuries in an auto accident? □ Yes □ No – If yes, explain: _____

_____

Present History: _____

_____

_____

Surgery: _____

Medications: _____

Accidents: _____

Family History: _____

PLEASE READ - Appointment Policy: Our time together is important. Please do your best to arrive on time for all of your appointments. As we get to know your body and treatment priorities, your appointment time will decrease. *If you arrive more than 5 minutes late to our scheduled time together, we may have to reschedule your appointment for another time or day.* Guardian Initials: _____