POJERO FAMILY
CHIROPRACTIC

153 Main Street, #2, Sayville, NY 11782 | (631) 244-0300
info@pojerofamilychiropractic.com | www.pojerofamilychiropractic.com

CHILD HEALTH HISTORY

We are happy you have chosen to have your child's spine checked! Many types of stresses (physical, mental, and chemical) can interfere with your child's growing spine and nervous system. Spinal health is an exciting new concept for many people, so PLEASE ask questions.

Child's Name: _____ Date of Birth: _____ Age: _____

Address: _____ City/State/Zip: _____

SS #: _____ Parents Email: _____

Home Phone #: _____ Parents Cell Phone #: _____

Mother's Name: _____ Father's Name: _____

Names & Ages of Siblings: _____

Reasons For Consulting Our Office: _____

Referred By: _____

Previous Chiropractic Care? ☐ Yes ☐ No If Yes, With Whom? _____

How Long Was Care Received? _____

Reason For Stopping Care? _____

Birth Place: ☐ Home ☐ Birth Center ☐ Hospital

Type: ☐ Vaginal ☐ C-Section Procedures: ☐ Forceps ☐ Vacuum Extraction

Was Delivery Long? ☐ Yes ☐ No Was Delivery Difficult? ☐ Yes ☐ No Labor Induced? ☐ Yes ☐ No

Epidural? ☐ Yes ☐ No Pain Medication? ☐ Yes ☐ No Was Baby Breech/in Utero-Constraint? ☐ Yes ☐ No

Was Baby Breast Fed? ☐ Yes ☐ No How Long? _____

Which sports does/did your child participate in:

☐ Soccer ☐ Football ☐ Gymnastics ☐ Cheerleading ☐ Karate ☐ Basketball ☐ Dance ☐ Lacrosse

☐ Other: _____

According to the National Safety Council, approximately 54% of infants fall head first from a high place (bed, changing table, etc.) during their first year of life. Has this happened to your child? ☐ Yes ☐ No

Comments: _____

_____

List any other fall or accidents: _____

_____

_____

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Check any of the following your child has suffered from:

- ☐ Ear Infections
- ☐ Chronic Colds
- ☐ Headaches
- ☐ Growing/Back Pains
- ☐ Constipation
- ☐ Scoliosis
- ☐ Asthma/Allergies
- ☐ A.D.D. / A.D.H.D.
- ☐ Colic
- ☐ Head Banging
- ☐ Seizures
- ☐ Digestive Problems
- ☐ Recurring Fevers
- ☐ Bed Wetting
- ☐ Other: _____

_____

_____

Medications:

How many rounds of antibiotics has your child taken in last 6 months? _____Lifetime?_____

Present Prescription Drugs: _____

Past Prescription Drugs: _____

Over the Counter Drugs *(Tylenol, cough syrups, laxatives, etc.)*: _____

Financial Information:

Who is responsible for this account? _____ Relationship: _____

Date of Birth:_____ SS#: _____ Employer: _____

What method of payment will you be using? ☐ Insurance ☐ Cash ☐ Check ☐ Other: _____

Insurance Company: _____ Policy/ID#: _____

Address: _____ Phone #:_____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize: _____ and whomever they may designate to administer care to my son/daughter:_____.

Signed: _____ Witnessed: _____

Relationship to minor: _____ Dated this _____ day of _____, 20_____.