Kramp Chiropractic

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Pediatric Form

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

Address: _____ City: _____ Prov: _____ Postal Code: _____

Home Phone #: ( ) _____ Birth Date: _____ Male ☐ Female ☐

Parent's Name: _____

Has your child ever seen a chiropractor before? Yes ☐ No ☐ If so, when? _____

Reason for consulting our office: _____

Who referred you to our office? _____

Amount of Health Coverage for: Chiropractic _____ Massage _____ Orthotics _____

Why this Form is Important

The vast majority of our pediatric patients have experienced literally dozens of impacts that could cause subluxated vertebrae. Subluxated vertebra can cause irritation to different fibers within nerves that can affect any organ or tissue, causing conditions now or in the future. Depending on the type and degree of the subluxated vertebra, the nerve pressure can be constant or occasional. Our goals are to address the issues that brought you to this office and offer your child the opportunity of improved health potential and wellness services in the future. Our only method is specific adjustments to correct vertebral subluxations. We believe the greatest Doctor is the one already inside each of our patients and we only help to maximize their inherent healing power without the use of drugs or surgery.

Birth Story

How long was labor? _____ How long did mother actually push? _____ Was mother induced? Yes ☐ No ☐

Nerve block? Yes ☐ No ☐ C-section? Yes ☐ No ☐ Head pulled? Yes ☐ No ☐ Forceps/vacuum? Yes ☐ No ☐

Additional comments: _____

Childhood Illnesses

List any illnesses experienced: _____

List all current medications: _____

Has your child received vaccinations? All ☐ Some ☐ None ☐ Has your child had any surgeries? Yes ☐ No ☐

Falls

Has your child fallen/jumped from a height over three feet? (ie. crib, bunk bed, tree) Yes ☐ No ☐

When was the most recent fall? _____ Any care given? _____

And the fall before that? _____ Any care given? _____

Accidents

Has your child been involved in a motor vehicle accident as a passenger? Yes ☐ No ☐

Briefly describe: _____

Any treatment received? _____

Sports/Recreation

What sports or recreational activities does your child do? _____

When was the most recent stress, strain, or injury while doing these activities? _____

Any care given? _____

Current Health Concerns

Please check any symptoms that your child has or has had previously:

☐ Headaches/Migraines	☐ Asthma	☐ Sleep problems	☐ Weight problems
☐ ADD/ADHD	☐ Postural Imbalance	☐ PDD/Autism	☐ Seizures
☐ Frequent colds	☐ Allergy/Sinus problems	☐ Bedwetting	☐ Ear infection
☐ Colic	☐ Digestive problems	☐ Scoliosis	☐ Growing/Back problems

Comments: _____

_____

_____

List any allergies: _____

List any genetic disorders: _____

List any other conditions: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine my child for evaluation.

Parent's Signature: _____ **Date:** _____