RATCLIFF CHIROPRACTIC

PEDIATRIC APPLICATION & CASE HISTORY FORM

Welcome to our practice! Please thoroughly complete all questions. Thank you.

Child's Name: _____ Today's Date: _____

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

Address: _____

City/State/Zip: _____

Home Phone #: _____ Mother's Work _____ Cell _____

Father's Work _____ Cell _____

Birthdate: _____/_____/_____ Age: _____

Who may we thank for referring you? _____

Pediatrician: _____ City _____

Natural childbirth? ____Yes ____ No Forceps used? ___ Yes ___ No

____ In-home ____ Birth Center ____ Hospital by: _____, M.D.

Earaches ___ Yes ___ No Tubes ___ Yes ___ No Colic ___ Yes ___ No

Medications: _____

Surgeries: _____

Complications of pregnancy?

_____

Complications of delivery?

_____

According to the National Safety Council, approximately 50% 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

Falls/Accidents? _____

Learned to walk _____ months Was a walker used? ___Yes ___No

Who was your prior doctor of chiropractic? _____

Was your prior chiropractic doctor present during delivery? ___ Yes ___ No

Have you noticed any abnormality with the way your child walks or runs? (Ex: limps, high hip, feet turn in or out)? _____

Other concerns you have? _____