VanQuaethem Chiropractic Maui
P.O. Box 12642
Lahaina, HI 96761

Dear New Patient,

It is a 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 to build better health for your family.

PEDIATRIC HISTORY FORM

Patient Name:_____ Social Security:_____

Address:_____ City:_____ State:_____ Zip:_____

Birthdate:_____/_____/_____ Sex: _____ Weight:_____ Height:_____

Parent/Guardians:_____

Purpose for contacting us?_____

Have you seen another doctor for this condition? ☐ Yes ☐ No

Doctor's Names & Prior treatments: _____

_____

Other health problems? _____

Family History: _____

Previous chiropractor: _____

Date of last visit: ____/____/____ Reason: _____

Name of Pediatrician: _____

Date of last visit: ____/____/____ Reason: _____

Are you satisfied with the care your child had received there? ☐ Yes ☐ No

Number of doses of antibiotics your child has taken:

During the past 6 months: _____, total during his/her lifetime: _____.

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

During the past 6 months: _____, total during his/her lifetime: _____.

Vaccination History:_____

Prenatal history:

Name of Obstetrician/Midwife:_____

Complications during pregnancy? ☐ Yes ☐ No List:_____

Complications during delivery? ☐ Yes ☐ No List:_____

Ultrasounds during pregnancy? ☐ Yes ☐ No How many? _____

Medications during pregnancy/delivery? ☐ Yes ☐ No List:_____

Location of birth: ☐ Hospital ☐ Birthing Center ☐ Home

Birth intervention: ☐ Forcepts ☐ Vacuum Extraction ☐ Cessarian section, emergency or planned?

Genetic disorders or disabilities: ☐ Yes ☐ No List:_____

Birth Weight: _____ lbs _____ oz Birth Length:_____ inches

Feeding History:

Breastfed: ☐ Yes ☐ No How long? _____ Formula fed: ☐ Yes ☐ No How long? _____

Introduced: Solids at _____ months Cows milk at _____ months

Food/juice allergies or intolerances: ☐ Yes ☐ No List: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

● Respond to sound _____ ● Respond to visual stimuli _____ ● Hold head up _____

● Sit up _____ ● Cross crawl _____ ● Stand alone _____ ● Walk alone _____

According to the national safety council, approximately 50% of children fall from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.). Was this the case with your child? ☐ Yes ☐ No

Is/has your child been involved in any high impact or contact type sports (i.e. Soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ☐ Yes ☐ No

List: _____

Has your child ever been involved in a car accident? ☐ Yes ☐ No List: _____

Has your child been seen on an emergency basis? ☐ Yes ☐ No List: -

_____

Other traumas not described above? ☐ Yes ☐ No List: _____

Prior surgery: ☐ Yes ☐ No List: _____

Menarche: ☐ Yes ☐ No Age: _____

Childhood Diseases:

Chicken Pox ☐ Yes ☐ No Age____ Mumps ☐ Yes ☐ No Age_____

Rubella ☐ Yes ☐ No Age____ Whooping Cough ☐ Yes ☐ No Age _____

Rubeola ☐ Yes ☐ No Age ____ Other _____Age _____

We are here to serve you, and encourage you to ask questions.
Your participation is vital and will help determine your results.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of insurance company: _____ Policy # _____

Signed: _____ Relation to child: _____ Date ____/____/____

Witnessed: _____ Date ____/____/____