Mascoto Chiropractic

Family Wellness Center

The Power that Made the Body Heals the Body

Pediatric History Form

Child's name:_____ Mother's Name:_____
Father's Name:_____ Mother's DOB:_____ Father's DOB:_____
Address:_____ City:_____ State:____ Zip:_____
Home #:_____ Mother's Work #:_____ Mother's Cell #:_____
Father's Work #:_____ Father's Cell #:_____ Email:_____
Insurance/Billing Information:_____ ID #: _____ Group #:_____
Child's SS#:_____ Insured SS#:_____ Insured Birthday:_____
Child's Birth Date: _____ Child's Age: ____ Gender of Child: Male Female
Names and Ages of Siblings: _____
Current Weight:_____ Current Height:_____

Pregnancy & Birth

Problems during Pregnancy: _____
Medications Taken during Pregnancy: _____
Did you use: Tobacco products? __ Alcohol? __ Over the Counter Medications? __ If so, explain:_____
_____
Child's Position during 3rd Trimester: Vertex ____ Breech ____ Face/Brow ____ Transverse ____
Place of Birth: Hospital ____ Home ____ Birthing Center/Midwife Assisted ____
Type of Delivery: Normal Vaginal ____ Cesarean ____ Forceps ____ Vacuum Extraction ____
Was Birth Induced? (Pitocin) Yes ___ No___ Was a Nerve Block Administered? Yes ___ No ___
Problems during Labor/Delivery: _____

Baby's Health after Birth

Birth Weight:_____ Birth Length:_____
Apgar Score: 1 minute _____ 5 minutes _____Did Child Show Signs of: Jaundice (yellow)___ Cyanosis (blue)___?
Birth Defects or Anomalies? Yes No If yes, please explain:_____
Medications at Birth: _____
Was Child Breastfed? _____ Bottle fed? _____ If Bottle, which formula? _____
How is Child Sleeping at Night? Well___ Fair___ Poor___ How many hours per night? _____

How old was the child when they:
Held head up:_____ Responded to Sound:_____ Followed Objects with Eyes:_____
Sat Alone:_____ Crawled:_____ Stood:_____ Walked:_____

Has the Child had any of the Following, if so, at what Age?
Measles:_____ Mumps:_____ Rubella:_____ Chickenpox:_____
Rubeola:_____ Whooping Cough:_____ Other:_____

Purpose of This Visit

Purpose of this visit - Primary Complaint:_____
When did this condition begin? _____ Was onset? Sudden ___ Gradual ___ Progressive over time ___
Has your child experienced this condition before? Yes __ No __ If yes, explain _____
Who have you seen for this condition? _____ What did they do? _____
Did condition improve or worsen? _____

Experience with Chiropractic

Has your child seen a chiropractor before this visit? Yes ___ No __ If yes, when? _____
Name(s) of previous chiropractor(s)? _____
Reason for visit with previous chiropractor(s): _____
Do you know that posture can influence your child's health? Yes ___ No ___
Have you noticed bad posture habits in your child? Yes __ No __
Explain: _____

Family History

List child's siblings, their age, & if they have any health problems: _____
_____
What is the health of child's parents? _____

Social/Medical History

How many times has your child taken antibiotics? _____ Has he/she taken them recently? Yes __ No __
Has he/she or is he/she currently taking a probiotic (i.e. acidophilus)? Yes __ No __
Please list any medications your child is currently taking and their purpose: _____
_____
Has Your Child had any Surgeries? Yes No If yes, Explain: _____
Has Your Child been Hospitalized? Yes No If yes, Explain: _____
Does your child have any health concerns? Yes No If yes, Explain: _____

Has your child been vaccinated? Yes No Has he/she received all recommended vaccinations? Yes No

What sports or recreational activities does your child do? _____

When was your child's most recent stress, strain, or injury while doing these activities? _____

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

Speed: _____ Front Collision ____ Side Collision ____ Rear-end collision ____

Was treatment received? Yes No If yes, Explain:_____

Cervical Spine (Neck):

Postural alterations from subluxations in the neck will cause weakness of the nerves into the head, shoulders, arms, and hands. Does your child have any of the following?

__ Neck pain
__ Pain into shoulders/arms/hands
__ Visual Disturbances
__ Hearing disturbances
__ Ear infections
__ Headaches
__ Dizziness
__ Recurrent Colds/Flu
__ Fainting
__ Seizures/Convulsions
__ Sinus problems
__ Allergies
__ Neck Problems
__ Arm Problems
__ Earaches

Thoracic Spine (Upper Back):

Postural alterations from subluxations in the upper back will weaken the nerves to the lungs and heart. Does your child have any of the following?

__ Upper Back Pain
__ Asthma/Wheezing
__ Shortness of Breath
__ Recurrent Lung Infections/Bronchitis
__ Heart Palpitations
__ Heart Problems
__ Tachycardia (increase heart rate)
__ Hypertension

Thoracic Spine (Mid Back):

Postural alterations from subluxations in the mid back will weaken the nerves to the ribs/chest & upper digestive tract including the liver, gallbladder, and kidneys. Does your child have any of the following?

__ Mid Back Pain
__ Poor Posture
__Scoliosis
__ Reflux
__ Poor Appetite
__ Colic
__ Diabetes
__ Hypoglycemia
__ Stomach Aches
__ Digestive problems
__ Liver problems
__ Gallbladder problems
__ Kidney problems

Lumbar Spine (Low Back):

Postural alterations from subluxations in the low back will weaken the nerves to the pelvic organs, hips, legs, and feet. Does your child have any of the following?

__ Low back pain
__ Bed Wetting
__ Weakness/Injuries in Hips/Knees/Ankles
__ Muscle Cramps in Legs/Feet
__ Constipation/Diarrhea
__ Trouble While Walking
__ Recurrent Bladder Infections
__ Leg Problems

Other:

__ Anemia
__ Growing Pains
__ Ruptures/Hernia
__ Broken Bones
__ Behavioral Problems
__ Muscles Pain
__ ADD/ADHD

Trauma to the Spine:

Has Your Child Ever Fallen:

__ From Crib
__ From Highchair
__ Off Swing
__ Off Monkey Bars
__ From Changing Table
__ In Baby Walker
__ Off Slide
__ Off Skate Board or Skates
__ From Bed or Couch
__ Down Stairs
__ Off Bicycle
__ Other _____

Terms of Agreement

When a person is seeking chiropractic and wellness care, it is very important for both parties (doctor and patient) to work toward the same goal. As a Chiropractic and Family Wellness Center, our main goal is to detect and correct/reduce the Vertebral Subluxation Complex. Here are some terms to better understand the method we use to attain this goal:

Wellness: A healthy balance of the mind, body, and spirit that results in an overall feeling of well-being & it's also more than just being disease or pain free.

Vertebral Subluxation: A misalignment of one or more of vertebrae in the spinal column which causes nerve alterations and interference of mental impulses, resulting in dysfunction of the body's God give ability to express its maximum health potential.

Adjustment: A specific force applied to assist the body's correction of vertebral subluxation. The subluxations adjusted in this office are detected during the initial exam and the beginning of each visit.

We do not offer to diagnose or treat a disease or condition other that vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. We also do not offer advice regarding treatment prescribed by other health care professionals. Our only objective in our office is to eliminate the nerve interference to the expression of our body's God given ability to heal from the inside out. The method used in this office to correct vertebral or extremity subluxation is specific spinal or extremity adjustments along with rehabilitation procedures.

Consent to Care

I do hereby authorize the doctor of Mascoto Chiropractic, PLLC to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments, and other chiropractic procedures, including various modes of physical therapy or other procedures that are advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and was informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctor's specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature:_____ Date:_____
(Parent's Signature if under age 18)