

**Confidential**  
**Pediatric / Child**  
**Patient Information**

Abundant Health Family Chiropractic, P.C.  
Kimberly A. Maxwell

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Date \_\_\_\_\_ Social Security # \_\_\_\_\_  
Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ Zip Code \_\_\_\_\_  
Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex: Female Male Weight \_\_\_\_\_ Height \_\_\_\_\_  
Names of Parents/Guardians: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Who referred you to my office? \_\_\_\_\_

**CONSENT TO TREAT A MINOR**

I hereby request and authorize this office and its doctor to perform diagnostic test and render chiropractic care as she deems necessary, to my minor child: \_\_\_\_\_ . As of this date, I have the legal right to select and authorize health care services for the minor child named above.

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Parent/Guardian Signature

Purpose of visit/specific concern? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Doctors seen for this condition: Yes No Dr.'s Name: \_\_\_\_\_

Treatment: \_\_\_\_\_

Previous Chiropractor: \_\_\_\_\_ Last Visit: \_\_\_\_\_

Reason for care: \_\_\_\_\_

Other Health Problems: \_\_\_\_\_

Name of Pediatrician: \_\_\_\_\_ Last Visit: \_\_\_\_\_

Reason for care: \_\_\_\_\_

Number of Doses of antibiotics your child has taken: \_\_\_\_\_ Last 6 months \_\_\_\_\_ Lifetime

Number of Doses of other prescription Medication your child has taken:  
\_\_\_\_\_ Last 6 months \_\_\_\_\_ Lifetime

Vaccination History: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**PRENATAL HISTORY:**

Name of Obstetrician/Midwife: \_\_\_\_\_

Complications during Pregnancy? YES NO List: \_\_\_\_\_

Complications During Delivery: YES NO List: \_\_\_\_\_

Ultrasounds During Pregnancy? YES NO Number: \_\_\_\_\_

Medications During Pregnancy? YES NO List: \_\_\_\_\_

Cigarette/Alcohol use during Pregnancy YES NO Describe: \_\_\_\_\_

Location of Birth: Hospital Birthing Center Home

Birth Intervention: Forceps Vacuum Extraction Caesarian Section

Birth Weight: \_\_\_\_\_ Birth Height: \_\_\_\_\_

**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          | _____ Hold head up | _____ Sit up      |
| _____ Respond to visual stimuli | _____ 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 you child?**

YES NO List: \_\_\_\_\_

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 Reason: \_\_\_\_\_

Other traumas not described above? YES NO List: \_\_\_\_\_

Prior Surgery Y N List: \_\_\_\_\_ Menarche: Y N Age: \_\_\_\_\_

\_\_\_\_\_