



# CASTLEWOOD CHIROPRACTIC

DR. BERTHA KREMER, D.C. / DR. MATTHEW D. KREMER, D.C.

## Welcome to Castlewood Chiropractic!

### Pediatric History Form

Full Name \_\_\_\_\_ Date \_\_\_\_\_

Parent's/Guardian Names \_\_\_\_\_

What patient prefers to be called \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Sex: M or F

Date of Birth (MM/DD/YY) \_\_\_\_\_ Parent's Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

Parent's Email Address \_\_\_\_\_ Child's School \_\_\_\_\_

How did you learn about our office? \_\_\_\_\_

Previous Chiropractic Care? Y N Approximate last visit date: \_\_\_\_\_

#### **Please check reasons for pursuing chiropractic care for your child:**

*He/She is continuing ongoing care from another chiropractor.*

*I recently had my spine checked and I see the value in getting my child checked.*

*I'm concerned about his/her health and I'm looking for answers.*

*I want to improve my child's immune function.*

*I have no idea why we're here. Please take the time to explain to me what you do for children.*

*He/she has a specific condition that concerns me.*

Explain condition or symptom:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long has your child had the condition? \_\_\_\_\_

Has your child had this or similar conditions in the past? \_\_\_\_\_

Is this condition getting (circle): Worse Better Same Recurring

How does this condition interfere with your child's daily routine? \_\_\_\_\_

When is your child's condition worse? (circle): Morning Afternoon Evening Night

What aggravates your child's condition? \_\_\_\_\_

What relieves your child's condition? \_\_\_\_\_

Type of previous treatment and/or surgery for this condition? \_\_\_\_\_



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## PERSONAL HEALTH HISTORY:

List prescription or over the counter medications now taken:

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List serious illnesses your child has had \_\_\_\_\_

Date of last pediatrician visit \_\_\_\_\_ Please list any abnormal findings \_\_\_\_\_

Known allergies \_\_\_\_\_

## PRENATAL HISTORY

Adopted? Y N

Complications during pregnancy? Y N List: \_\_\_\_\_

Ultrasounds during pregnancy? Y N Number: \_\_\_\_\_

Medications/drugs/caffeine during pregnancy? Y N List: \_\_\_\_\_

Cigarette/alcohol use during pregnancy? Y N

Location of birth: \_\_\_ Hospital \_\_\_ Birthing Center \_\_\_ Home

Birth Intervention: \_\_\_ Mother Induced \_\_\_ Mother medicated (Pitocin, etc) \_\_\_ Caesarian Section  
\_\_\_ Forceps \_\_\_ Vacuum Extracted \_\_\_ Baby given medication after delivery

Complications during delivery? Y N List: \_\_\_\_\_

Genetic Disorders or Disabilities? Y N List: \_\_\_\_\_

Breast Fed? Y N How Long? \_\_\_\_\_ Formula Fed? Y N How Long? \_\_\_\_\_

Food Allergies or Intolerances? Y N List: \_\_\_\_\_

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (ie. A bed, changing table, down stairs, etc.) Was this the case with your child?  
\_\_\_ Y \_\_\_ N List: \_\_\_\_\_

Is/Has your child been involved in any high impact or contact type sports (ie. soccer, football, gymnastics, hockey, baseball, cheerleading, martial arts, etc.)? \_\_\_ Y \_\_\_ N

List: \_\_\_\_\_

Has your child been seen on an Emergency Basis? \_\_\_ Y \_\_\_ N

List: \_\_\_\_\_



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**Please circle any of the following body signals your child has had or is presently having:**

- |                 |                     |                      |              |
|-----------------|---------------------|----------------------|--------------|
| Fractured Bones | Digestive Problems  | Asthma               | Diabetes     |
| Dislocations    | Knocked Unconscious | Sinus Problems       | Fainting     |
| ADD/ADHD        | Frequent Colds      | Convulsions/Seizures | Headaches    |
| PDD/Autism      | Meningitis          | Bed Wetting          | Allergies    |
| Ear Infections  | Scoliosis           | Growing/Back Pains   | Car Accident |
| Colic           |                     |                      |              |

Other \_\_\_\_\_

Surgeries \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### **AUTHORIZATION:**

It is important that our patients and we have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called, we do not offer to treat it. Our primary practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe that the greatest Doctor is the one already inside each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept, if eligible, chiropractic care on this basis. In addition, I understand that all first visit charges are payable when services are rendered.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian's Signature Authorizing Care for Minor

\_\_\_\_\_  
Date