



Pediatric Health Profile

Child's Name _____ Date _____

Address _____

Date of Birth _____ ☐ Female ☐ Male

Parent/Guardian Name _____ Phone Number _____

E-mail Address _____

Were you referred to this office? If so, who referred you? _____

Why have you brought your child to see us? ☐ General check-up ☐ Help with a particular symptom/condition
(If particular symptom, please describe) _____

Has your child had previous Chiropractic care? ☐ No ☐ Yes If yes, date of last adjustment _____

What type of birth did your child have?

☐ Normal Vaginal ☐ Breech ☐ Vacuum Extraction ☐ Caesarean ☐ Forceps

How many hours does your child sleep per night? _____

Describe the quality of your child's sleep: ☐ Good ☐ Fair ☐ Poor

When was your child last vaccinated? _____

Has your child been in a motor vehicle accident? ☐ No ☐ Yes If yes, when _____

Is your child sensitive to any of the following? ☐ Loud Noises ☐ Crowded Places ☐ Light

☐ Other (please describe) _____

Has your child experienced any of the following? (Please provide relevant details)

☐ Colic or irritability _____

☐ Skin conditions _____

☐ Asthma or allergies _____

☐ Ear infections _____

☐ Behavioral or learning difficulties _____

☐ Recurrent/persistent colds or infections _____

☐ Difficulties falling or staying asleep _____

☐ Restricted movement of any part of body _____

Additional comments/concerns that brought you to our office: _____

Parent/Guardian Signature _____

Date _____

MINOR/CHILD CONSENT

Adams-Edison Chiropractic Wellness

105 S. Pearl St.

Tecumseh, MI 49286

Telephone: (517) 423-WELL

I am the parent, guardian, or personal representative of _____

_____ and there are no court orders now in effect that

Please Print Name of Minor/Child

prohibit me from signing this consent. I do hereby request and authorize the doctor and practice staff to perform necessary services for the child named above, including but not limited to x-rays, and treatment, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient