GREATER ROCHESTER
CHIROPRACTIC
Collaborative Spine Care

30 ALLENS CREEK RD, ROCHESTER, NY 14618
WWW.GRCHEALTH.COM
(585) 442-3220

Confidential Pediatric Patient Information (Age 6 to 12)

Name:	Date	
Address/City/State/ZIP:		
Date of Birth:	Age:	Gender: M F
Pediatrician Name:		
Pediatrician Address/Phone:		
Referred by:		

Parent Name(s):
Parent Phone Number(s):
Parent Email Address (optional for appointment reminders):
Siblings (names and ages):

Description of Condition

Describe the reason(s) for your visit today: _____

_____

_____

_____

When did the symptoms begin? How did they start? _____

_____

_____

What seems to make the symptoms better? _____

_____

_____

What seems to make the symptoms worse? _____

_____

What, if any, are the effects of the problem on body function and daily activities?

_____

_____

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Have you seen another doctor or healthcare provider for these symptoms? If yes please indicate the name and type of provider(s): _____

Is there any additional information about the reason for this visit that you would like the doctor to know? _____

_____

Current Health and Wellness

Does your child have any ongoing diagnoses, health problems, or do you have any concerns about their health (in addition to the reason you brought them in today)?_____

_____

_____

Please list any medications/supplements your child is currently taking, including over-the-counter medications: _____

_____

Has your child met age-appropriate growth and developmental milestones? Yes No
If no, where does/is your child needing/receiving support? _____

_____

How does your child sleep at night? _____

_____

Do you currently have, or have you in the past had concerns about your child's feeding abilities?_____

Has your child been immunized (circle one)? Yes Delayed Schedule No Declined
If yes, are the immunizations up to date? _____

Have you noticed any reactions to immunizations and if so please describe: _____

_____

_____

Please list any illnesses, surgeries or hospital visits with reasons and approximate dates:

_____

_____

_____

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Were there any problems or significant events in your pregnancy or your child's labor/birth that may be contributing (If yes, please describe. If your child is adopted please answer to the best of your ability.)? _____

_____

_____

Does your child have any allergies you are aware of (if yes, please list)? _____

_____

_____

Has your child had any ear infections? (circle one) Yes No
If Yes, at what age(s): _____

_____

_____

Date of last physical examination: _____

Has your child had previous chiropractic care? (circle one) Yes No

Consent to Treat a Minor

I hereby authorize the doctors at **Greater Rochester Chiropractic** to evaluate and administer chiropractic care as deemed necessary to my child at this and future visits. I understand I am welcome and encouraged to ask questions at any point before, during, or after treatment(s).

I acknowledge that I am financially responsible for any and all fees charged by **Greater Rochester Chiropractic** and the payment will be made as soon as services are provided.

Print Name of Parent/Guardian: _____ Relationship: _____

Signature of Parent/Guardian: _____ Date: _____