

# Stuckey Family Chiropractic Jason Stuckey, D.C.

2510 Mineral Point Ave.- Janesville, WI 53548  
Phone: 608-758-1700 Fax: 608-758-1800

## Pediatric Health History

---

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
Zip Code: \_\_\_\_\_ Child's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Purpose of Appointment: \_\_\_\_\_  
Mother's Name: \_\_\_\_\_ Phone #: (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Father's Name: \_\_\_\_\_ Phone #: (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Legal Guardian: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

---

Age (years) \_\_\_\_\_ (months) \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Sex: Male/Female Siblings and Ages: \_\_\_\_\_  
Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ Present Weight: \_\_\_\_\_  
Present Height \_\_\_\_\_  
Was the birth: ( ) Normal vaginal ( ) Cesarean ( ) Breech ( ) Forceps  
( ) Vacuum extraction ( ) Home birth ( ) Birthing Center  
Pregnancy problems: \_\_\_\_\_  
Labor or delivery problems: \_\_\_\_\_  
Congenital defects/anomalies: \_\_\_\_\_ APGAR scores: \_\_\_\_\_  
Was there present at birth: ( ) Meconium (black/green infant feces) ( ) cyanosis (lack of oxygen)  
( ) Jaundice  
Obstetrician/Midwife: \_\_\_\_\_ Address: \_\_\_\_\_  
Pediatrician/Family MD: \_\_\_\_\_ Address: \_\_\_\_\_  
Has this child had vaccinations: Yes/No; if yes please list dates:  
HepB \_\_\_\_\_ OPV \_\_\_\_\_ DTP \_\_\_\_\_ MMR \_\_\_\_\_ HiB \_\_\_\_\_ VAR \_\_\_\_\_  
Has this child had any of the following childhood "diseases," if so, please list dates:  
Measles \_\_\_\_\_ Chicken Pox \_\_\_\_\_ Whooping Cough \_\_\_\_\_ Mumps \_\_\_\_\_  
Other \_\_\_\_\_  
Date and purpose of last Medical Doctor visit: \_\_\_\_\_  
Has this child been treated for an emergency? Yes/No; Please describe: \_\_\_\_\_  
\_\_\_\_\_  
Surgeries: \_\_\_\_\_  
Medications: \_\_\_\_\_  
Accidents: \_\_\_\_\_

Has this child ever suffered with any of the following:

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Allergies              | <input type="checkbox"/> Colic              | <input type="checkbox"/> "Growing Pains"   | <input type="checkbox"/> Orthopedic problems |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Headaches         | <input type="checkbox"/> Paralysis           |
| <input type="checkbox"/> Arm problems           | <input type="checkbox"/> Convulsions        | <input type="checkbox"/> Heart trouble     | <input type="checkbox"/> Poor appetite       |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Hyperactivity     | <input type="checkbox"/> Rupture/hernias     |
| <input type="checkbox"/> Backaches              | <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Hypertension      | <input type="checkbox"/> Rheumatic fever     |
| <input type="checkbox"/> Sinus Trouble          | <input type="checkbox"/> Digestion problems | <input type="checkbox"/> Fainting          | <input type="checkbox"/> Joint problems      |
| <input type="checkbox"/> Sugar levels(high/low) |   | <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Leg problems        |
| <input type="checkbox"/> Muscle jerking         | <input type="checkbox"/> Bed wetting        | <input type="checkbox"/> Behavior problems | <input type="checkbox"/> Earaches            |
| <input type="checkbox"/> Neck problems          | <input type="checkbox"/> Tuberculosis       | <input type="checkbox"/> Broken bones      | <input type="checkbox"/> Ear infection       |
| <input type="checkbox"/> Neuritis               | <input type="checkbox"/> Walking Problems   | <input type="checkbox"/> Colds/Flu         |  |

Overall, how would you rate the health of this child since birth: \_\_\_\_\_

Is there anything else we should know about this child? \_\_\_\_\_

Diet: \_\_\_\_\_

Environmental Factors: \_\_\_\_\_

**Personal injury only:**

Was this child injured in an automobile accident? Yes/No; please explain: \_\_\_\_\_

Was this child riding in a car seat? Yes/No; If no, please explain: \_\_\_\_\_

Was this child in a booster seat? Yes/No

Was the car set/booster seat in the FRONT or the REAR (left/center/right), facing FORWARD or BACKWARD?

Was this child struck by an air bag? Yes/No

Was the vehicle struck from the REAR/FRONT/LEFT/RIGHT side?

List any visible bumps, bruises, etc. on this child that were caused by this accident:

---

**Insurance Information**

(please make sure front office has a copy of your card)

Name of Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Date of Birth \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Insured's Work Place \_\_\_\_\_ Insured's Work Phone# \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Insured's Address if different than patient address: \_\_\_\_\_

---

I certify that the information on this form is true to the best of my knowledge.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

Stuckey Family Chiropractic  
2510 Mineral Point Avenue  
Suite 100  
Janesville, WI 53548

### TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**ADJUSTMENT**-An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

**HEALTH**-A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

**VERTEBRAL SUBLUXATION**-A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contradicted. Again, it is the responsibility of the patient to make it known or to learn through health care procedures, whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures.

I, \_\_\_\_\_ have read and fully understand the above statements.

(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

### CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

### PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.  
Date of last menstrual period \_\_\_\_\_

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)