



PEDIATRIC HISTORY FORM

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you.

Patient Name: _____ S.S #: _____

Address: _____ City/ State/ Zip: _____

Home Phone: _____ Parents Work Phone: _____ Birth date: ____/____/____

Sex: _____ Weight: _____ Height: _____ Referred By: _____

Name of Parents/ Guardian: _____

PURPOSE FOR CONTACTING US? _____

Other Doctors Seen for this Condition: ____N ____Y Doctors name and prior treatment: _____

Other Health Problems: _____

Check any of the following conditions that your child has suffered from in the past six months:

- | | | | | |
|--|---|---------------------------------------|--|--|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Asthma/ Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD | <input type="checkbox"/> Recurring Fever | <input type="checkbox"/> Growing/ Back Pains |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Temper Tantrum | <input type="checkbox"/> Other: _____ |

Family History: _____

Previous Chiropractor: _____ Last Date of Visit: _____

Reason: _____

Name of Pediatrician/ Doctor: _____ Date of Last Visit: _____

Number of doses of Antibiotics your child has taken: During last 6 months _____ Total during lifetime: _____

Number of doses of other Prescription Medication your child has taken: During last 6 months: _____ Total during lifetime: _____

Vaccination History: _____

Prenatal History:

Complications during pregnancy? ____N ____Y Details: _____

Ultrasounds During Pregnancy? ____N ____Y Number of Ultrasounds during pregnancy: _____

Medications during pregnancy/ delivery? ____N ____Y List any: _____

Cigarette/ Alcohol use during pregnancy? ____N ____Y

Birth Intervention: _____ Forceps: _____ Vacuum Extraction: _____ Caesarian Section- ___Emergency___ Planned

Complications during delivery? _____ N _____ Y List: _____

Genetic Disorders or Disabilities: _____ N _____ Y List: _____

Birth Weight: _____ Birth length: _____ APGAR Score: _____, _____

Feeding History:

Breast Fed: _____ N _____ Y How long? _____

Formula Fed: _____ N _____ Y How long? _____

Introduced to solids at: _____ Months, Cows Milk at _____ age.

Food/ Juice Allergies or Intolerances: _____ N _____ Y List: _____

Development 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 | _____ Cross crawl |
| _____ Respond to Visual Stimuli | _____ Stand alone |
| _____ Hold head up | _____ Walk alone |
| _____ Sit up | |

According to the National Safety council approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc) Was this the case with your child? _____Y _____N

Was/ has your child been involved in any high impact/contact sports (i.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc)?

_____Y _____N List: _____

Has your child ever been involved in a Car accident? _____ N _____ Y List: _____

Has your child been seen on an emergency basis? _____ N _____ Y List: _____

Other Traumas not described above? _____ N _____ Y List: _____

Prior Surgery: _____ N _____ Y List: _____

Menarche: _____ N _____ Y Age: _____

Childhood Diseases:

Chicken Pox: N / Y Age: _____ Mumps: N / Y Age: _____ Rubella: N / Y Age: _____

Whooping Cough: N / Y Age: _____ Rubeola: N / Y Age: _____ Other: N / Y Age: _____

WE ARE HERE TO SERVE, AND ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my son/ daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed by Parent/ Guardian: _____ Date: _____