



PEDIATRIC HISTORY FORM



Dear New Patient:

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 to build better health for your family.

Patient Name: _____ S.S.#: _____
Address: _____ City: _____
State: _____ Zip: _____ Home Phone: _____
Birth Date: ____ / ____ / ____ Work Phone: _____
Sex: _____ Weight: _____ Height: _____ Referred By: _____
Names of Parents / Guardians: _____

Purpose For Contacting Us?

Other Doctors Seen for this Condition: _____ N _____ Y, Doctor's Name and Prior Treatments: _____

Other Health Problems? _____

Check any of the following conditions your child has suffered from during 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 Fevers | <input type="checkbox"/> Growing / Back Pains |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Other _____ |

Family History: _____

Previous Chiropractor: _____

Date of Last Visit: ____ / ____ / ____ Reason: _____

Name of Pediatrician: _____

Date of Last Visit: ____ / ____ / ____ Reason: _____

Are you satisfied with the care your child has received there? ____ N ____ Y

Number of doses of antibiotics your child has taken:

During the past six months: _____ Total during his/her lifetime: _____

Number of Doses of other prescription medications your child has taken:

During the past six months: _____, Total during his/her lifetime: _____

Vaccination History: _____

Prenatal History:

Name of Obstetrician / Midwife: _____

Complications during pregnancy? ____ N ____ Y, List: _____

Ultrasounds during pregnancy? ____ N ____ Y, Number: _____

Medications during pregnancy? ____ N ____ Y, List: _____

Cigarette / Alcohol use during pregnancy: ____ N ____ Y

Location of birth : _____ Hospital _____ Birthing Center _____ Home

Birth Intervention: ____ Forceps ____ Vacuum Extraction ____ Cesarean Section, Emergency or Planned?

Complications During Delivery? ____ N ____ Y, List: _____

Genetic disorders or disabilities: ____ N ____ Y, List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

Feeding History:

Breast fed: _____ N _____ Y, How long?: _____ Formula fed: _____ N _____ Y, How Long?: _____ Type: _____
Introduced to Solids at: _____ Months, Cows' milk at _____ Months
Food / Juice Allergies or Intolerances: _____ N _____ Y, List: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor or chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to Sound
_____ Respond to Visual Stimuli
_____ Hold Head Up
_____ Sit Up
_____ Cross Crawl
_____ Stand Alone
_____ Walk Alone

According to the National Safety Council, approximately 50% of the 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? _____ N _____ Y

Is / has your child been involved in any high impact or contact type sports (i.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? _____ N _____ Y, 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 you, 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.

Name of Insurance Company: _____ Policy#: _____

Signed: _____ Witnessed: _____ Date: ___ / ___ / ___