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 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 Names and Prior Treatments:

____

____

Other Health Problems? ____

Check any of the Following Conditions Your Child has Suffered from During the Past Six Months:

____Ear Infections
____Chronic Colds
____Asthma/ Allergies
____Bed Wetting
____Scoliosis
____Headaches
____Recurring Fevers
____Car Accident
____Seizures
____Digestive
____Growing/ Back Pains
____Temper Tantrums
____Bed Wetting
____ Car Accident
____Other__________________
_____ADHD
_____ Colic

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 last 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: ________ List: ____________________________

Vaccination History:
____

Prenatal History:

Name of Obstetrician/Midwife: ____

Complications During Pregnancy? _____N _____Y, List: ______________________________

Ultrasound During Pregnancy? _____N _____Y, Number: ______

Medications During Pregnancy/ Delivery? _____N _____Y List: __________________________

Cigarette/ Alcohol Use During Pregnancy? _____N _____Y

Location of Birth: _____H _____Birthing Center _____Home

Birth Intervention: _____Forceps _____Vacuum Extraction _____Ceasarian 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, Cow's 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 chiropractor for prevention and detection of vertebral subluxation (spine 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 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? ______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 Ever 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 TO ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION AND 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: _______/_______/_______