

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: _____ Home Phone: _____ S.S.#: _____
Address: _____ City: _____ State: _____ Zip: _____
Age: _____ Birth Date: _____ Sex: M / F Referred by: _____
Name of Parents/Guardians: _____ Work Phone: _____

Purpose for contacting us? () Optimal Health Check-up () Specific Health Concern or Challenge
Please explain: _____

Other Doctors seen for this condition: N / Y Doctors names and prior treatments: _____

Other health problems? _____

Circle any of the following conditions your child has suffered from during the past six months:

Ear Infections	Scoliosis	Seizures	Chronic Colds	Headaches
Asthma/Allergies	ADHD	Recurring fevers	Digestive problems	Growing pains
Car accident	Bed Wetting	Temper Tantrums	Colic	Other: _____

Family History: _____

Previous Chiropractor: _____ Date of last visit: _____

Name of Pediatrician: _____ Date of last visit: _____

Reason: _____

Number of doses of antibiotics your child has taken :

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

Number of doses of Prescription Medication your child has taken:

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

Vaccination history: _____

Adverse reactions: () fever () high pitched screaming () redness at injection site () seizure
() lethargy () diarrhea () other

Prenatal history:

Name of Obstetrician/Midwife: _____

Complications during pregnancy? N / Y List: _____

Ultrasounds during pregnancy? N / Y Number: _____ Cigarette/Alcohol use during pregnancy? _____

Medications during pregnancy/delivery? N / Y List: _____

Location of birth: () Home () Birthing Center () Hospital () Other: _____

Birth intervention: () forceps () vacuum extraction () C-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? _____ Difficulties? N / Y

Formula Fed N / Y How long? _____ Type: _____

Introduced to solids at _____ months?

Does your child consume: () cow's milk () meat-including chicken () fish

Food/Juice allergies or intolerances? N / Y

List: _____

Developmental History:

During the following times your child's Nervous System and Spine are 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 _____ Hold head up _____ Sit up
_____ Cross crawl _____ Stand alone _____ Walk alone
_____ Respond to visual stimuli

According to the National Safety Council, approximately 50% of all children fall head first from a high place during their first year of life (a bed, changing table, down stairs, etc.). Was this the case with your child? N / Y What happened? _____

Is/has your child been involved in any high impact or contact type sports (soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.) N / Y List: _____

What other hobbies or activities does your child participate in? _____

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: _____

Has your child ever broken a bone? N / Y Concussion? N / Y Bloody noses? N / Y
Other traumas not listed above? N / Y List: _____

Prior surgery N / Y List: _____

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: _____

Does your child have high energy? N / Y

How is your child's immune system? _____

Do you feel your child is as healthy as he/she can be? N / Y

Is there any other information you would like to share at this time? _____

AUTHORIZATION FOR CARE OF A 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: _____ Date: _____ Witness: _____