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:

□ Ear Infections	□ Scoliosis	□ Seizures	□ Chronic Colds	□ Headaches
□ Asthma/ Allergies	□ Digestive Problems	□ ADHD	□ Recurring Fever	□ Growing/ Back Pains
□ Colic	□ Bed Wetting	□ Car Accident	□ Temper Tantrum	□ 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

_____ Respond to Visual Stimuli

_____ Hold head up

_____ Sit up

_____ Cross crawl

_____ Stand alone

_____ Walk alone

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: _____