

# PEDIATRIC HISTORY FORM

## Dear New Patient,

It is our 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's Full Name: \_\_\_\_\_

What do you prefer to be called? \_\_\_\_\_

Legal Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mailing Address: (if different from Legal Address) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Referred by: \_\_\_\_\_

Names of Parents / Gauradians: \_\_\_\_\_

Work Phone: \_\_\_\_\_

**Has your child been diagnosed with a scoliosis?** \_\_\_\_No \_\_\_\_Yes;

Doctors' 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     Scoliosis     Seizures     Chronic Colds     Headaches  
 Asthma/Allergies     ADHD     Recurring fevers     Colic     Growing/Back Pain  
 Bed wetting     Car Accident     Digestive Problems     Temper Tantrums     Other \_\_\_\_\_

Family History: \_\_\_\_\_

Previous Chiropractor: \_\_\_\_\_ Date of last visit: \_\_\_\_\_ Reason: \_\_\_\_\_

Name of Pediatrician: \_\_\_\_\_ Date of last visit: \_\_\_\_\_ Reason: \_\_\_\_\_

Are you satisfied with the care which your child has received there? \_\_\_\_No \_\_\_\_Yes

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: \_\_\_\_\_ List: \_\_\_\_\_

Vaccination History: \_\_\_\_\_

## Prenatal History:

Name of Obstetrician / Midwife: \_\_\_\_\_

Complications during pregnancy? \_\_\_\_No \_\_\_\_Yes; List: \_\_\_\_\_

Ultrasounds during pregnancy? \_\_\_\_No \_\_\_\_Yes; Number: \_\_\_\_\_

Medications during pregnancy / delivery? \_\_\_\_No \_\_\_\_Yes; List: \_\_\_\_\_

Cigarette / Alcohol use during pregnancy? \_\_\_\_No \_\_\_\_Yes

Location of Birth: \_\_\_\_\_ Hospital \_\_\_\_\_ Birthing Center \_\_\_\_\_ Home \_\_\_\_\_ Other: \_\_\_\_\_

Birth Intervention: \_\_\_\_\_ Forceps \_\_\_\_\_ Vacuum Extraction

\_\_\_\_\_ Cesarean Section : emergency or planned (please circle)

Complications during delivery? \_\_\_\_\_ No \_\_\_\_\_ Yes List: \_\_\_\_\_

Genetic Disorders or Disabilities: \_\_\_\_\_ No \_\_\_\_\_ Yes List: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ APGAR Scores: \_\_\_\_\_, \_\_\_\_\_

Was delivery within 2 weeks of due date? \_\_\_\_\_ Yes \_\_\_\_\_ No # of days premature / late: \_\_\_\_\_

### Feeding History:

Breast fed: \_\_\_\_\_ No \_\_\_\_\_ Yes How long? \_\_\_\_\_

Formula fed: \_\_\_\_\_ No \_\_\_\_\_ Yes How long? \_\_\_\_\_ Type: \_\_\_\_\_

Introduced to solids at: \_\_\_\_\_ months; Cow's Milk at \_\_\_\_\_ months

Food / Juice Allergies or Intolerances: \_\_\_\_\_ No \_\_\_\_\_ Yes List: \_\_\_\_\_

### Developmental History:

During the following times your child 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 1st year of life (i.e. a bed, changing table, stairs, etc.) Was this the case with your child? \_\_\_\_\_ No \_\_\_\_\_ Yes

Is / Has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.) \_\_\_\_\_ No \_\_\_\_\_ Yes List: \_\_\_\_\_

Has your child ever been involved in a car accident? \_\_\_\_\_ No \_\_\_\_\_ Yes List: \_\_\_\_\_

Has your child been seen on an emergency basis? \_\_\_\_\_ No \_\_\_\_\_ Yes List: \_\_\_\_\_

Other traumas not described above? \_\_\_\_\_ No \_\_\_\_\_ Yes List: \_\_\_\_\_

Prior surgery: \_\_\_\_\_ No \_\_\_\_\_ Yes List: \_\_\_\_\_

Menarche: \_\_\_\_\_ No \_\_\_\_\_ Yes 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 for 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: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_