

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 Name: _____ S.S.# _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Birth Date: _____ / _____ / _____ Work Phone: _____

Sex: _____ Weight: _____ Height: _____ Referred by: _____

Names of Parents / Gauradians: _____

Purpose For Contacting Us? _____

Other doctors seen for this condition: 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

Ceasarian 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: _____ / _____ / _____

