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: ______________________________ 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 , 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
- ☐ Asthma / Allergies
- ☐ Colic
- ☐ Scoliosis
- ☐ Digestive Problems
- ☐ Bed Wetting
- ☐ Seizures
- ☐ ADHD
- ☐ Car Accident
- ☐ Chronic Colds
- ☐ Recurring Fevers
- ☐ Temper Tantrums
- ☐ Headaches
- ☐ Growing / Back Pains
- ☐ Other __________

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 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 ? _____ N _____ Y , List: ______________

Ultrasounds During Pregnancy ? _____ N _____ Y , Number: _____

Medications During Pregnancy / Delivery ? _____ N _____ Y , List: ______________

Cigarette / Alcohol Use During Pregnancy: _____ N _____ Y

Location of Birth: _____ Hospital _____ 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 , Cows' 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 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 Saftey 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 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 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.

Name of Insurance Company: _______________ Policy #: _______________

Signed: _______________ Witnessed: _______________ Date: ____ / ____ / ____

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