



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 to build better health for your family.

Patient Name: _____ SS#: _____ - _____ - _____
Address: _____ City: _____
State: _____ Zip: _____ Birth Date: ____/____/____ Sex: male Female
Weight: _____ Height: _____ Referred By: _____
Names of Parents/Guardians: _____ E mail: _____
Home Phone: _____ - _____ Business Phone: _____ - _____ Cell: _____ - _____

Purpose for Contacting Us _____

Other Doctors seen for this condition: Yes No Type (DC, MD, etc...)? _____
Doctor's Names/Prior Treatments: _____

Check any of the following conditions your child has suffered from during the past 6 months:

- | | | | |
|--|---|---------------------------------------|---|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic Colds |
| <input type="checkbox"/> Asthma/ Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD | <input type="checkbox"/> Recurring Fevers |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Temper Tantrums |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Growing/Back Pains | <input type="checkbox"/> Other _____ | |

Family History: _____
Previous Chiropractor: _____ Date of last visit: _____
Reason: _____
Name of Pediatrician: _____ Date of last visit: _____
Reason: _____

Were you satisfied with the care your child received: Yes No If No, Why not _____
Antibiotics? Yes No If Yes, please describe the number of doses your child has taken:
In last 6 months: _____ Total during lifetime: _____
Prescription Medications? Yes No If Yes, please describe the number of doses your child has taken:
In last 6 months: _____ Total during lifetime: _____
List: _____

Vaccination History: No vaccinations all recommended some of the recommended
Were there any reactions to the Vaccination? Yes No Explain _____

PRENATAL HISTORY

Name of Obstetrician/ Midwife: _____

Complications during pregnancy: Yes No If yes, please explain: _____
Ultrasounds during pregnancy: Yes No If yes, How many? _____
Cigarette/ Alcohol use during pregnancy: Yes No Quantity/Duration: _____
Location of Birth (check all that apply): Hospital Birthing Center Home Water Birth

BIRTH INTERVENTION

Forceps: _____ Vacuum Extraction: _____ Caesarian Section: Planned Emergency
Complications during delivery: Yes No List: _____
Genetic Disorders or disabilities: Yes No List: _____

FEEDING HISTORY

Breast Fed: Yes No How Long: _____
Formula Fed: Yes No How Long: _____
Introduced to solids at Month: _____ Started Cow's Milk at Month: _____
Allergies/ Intolerance: Yes No List: _____

DEVELOPMENTAL HISTORY

During this time your child's spine is most vulnerable to stress and should routinely be checked by a doctor or chiropractor for prevention and early detection of Vertebral Subluxation Complex (VSC). At what age was your child able to?

Respond to sound: _____ Hold Head Up: _____ Crawl: _____ Roll over: _____
Respond to Visual Stimuli: _____ Sit Up: _____ Stand Alone: _____ Walk on their own: _____

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. bed, changing table, down stairs, etc.).

Was this the case with your child: Yes: _____ No: _____ List: _____
Is/has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? Yes No List: _____
Has your child ever been involved in a car accident? Yes No List: _____
Has your child been seen on an emergency basis? Yes No List: _____
Other traumas not described above? Yes No List: _____
Prior Surgery? Yes No List: _____
Menarche? Yes No List: _____

CHILDHOOD DISEASES

Chicken Pox Yes No Age: _____ Rubeola Yes No Age: _____
Rubella Yes No Age: _____ Mumps Yes No Age: _____
Whooping Cough Yes No Age: _____ Other: _____ Age: _____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctor 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.

Insurance Company: _____ Policy #: _____
Signed: _____ Witnessed: _____ Date: _____