

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 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: _____ Birth Date: _____ / _____ / _____
Home Phone: _____ Work Phone: _____
Sex: _____ Weight: _____ Height: _____ Referred By: _____
Name of Parents / Guardians: _____

Purpose For Contacting Us?

Other Doctors Seen for this Condition: _____ N _____ Y , Doctor's Name 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 ___ Digestive Problems ___ ADHD ___ Recurring Fever ___ Growing / Back Pains
___ Colic ___ Bed Wetting ___ Car Accident ___ 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 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

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Birth Intervention: _____ Forceps _____ Vacuum Extraction
_____ Caesarian Section, Emergency or Planned? (Circle One)
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	_____ 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 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 If yes, please list and describe: _____

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 _____	Rubella: N / Y, Age _____	Rubeola: N / Y, Age _____
Mumps: N / Y, Age _____	Whooping Cough: 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: ____ / ____ / ____