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: _____ 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, Doctor's 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	____Bed Wetting	_____ADHD
____Chronic Colds	____Headaches	____Digestive	____ Car Accident	_____ Colic
____Asthma/ Allergies	____Recurring Fevers	____Growing/ Back Pains		
____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 last 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: _____

Ultrasound During Pregnancy? _____N _____Y, Number: _____

Medications During Pregnancy/ Delivery? _____N _____Y List: _____

Cigarette/ Alcohol Use During Pregnancy? _____N _____Y

Location of Birth: _____H _____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, Cow's 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 chiropractor for prevention and detection of vertebral subluxation (spine 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 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 List: _____
Has Your Child Ever 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 TO ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION AND 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: _____/_____/_____