PEDIATRIC HISTORY FORM

Dear Practice Member,

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: _____/_____/_____ Sex: ❑ Male ❑ Female Weight: _____ Height:_____

Name of Parents / Guardians: _____ Work Phone:_____

Referred By: _____

Primary Complaint?_____

Other Doctors seen for this condition: ❑ No ❑ Yes If 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	❑ Digestive Problems	❑ ADHD	❑ Recurring Fevers	❑ Growing / Back Pains
❑ Colic	❑ Bed Wetting	❑ Car Accident	❑ Temper Tantrums	❑ Other:_____

Family History:_____

Previous Chiropractic care: ❑ No ❑ Yes Chiropractor name: _____

Date of last visit: _____/_____/_____ Reason: _____

Name of Pediatrician: _____

Date of last visit: _____/_____/_____ Reason: _____

Are you satisfied with the care 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
Birth Intervention: ❑ Forceps ❑ Vacuum Extraction ❑ Caesarian Section: Emergency or Planned?

Complications during delivery? ❑ No ❑ Yes List: _____

Genetic Disorders or Disabilities? ❑ No ❑ Yes List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____ , _____

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 Intolerance: ❑ No ❑ Yes 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? ❑ 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: ❑ No ❑ Yes, Age: _____ Mumps: ❑ No ❑ Yes, Age: _____

Rubella: ❑ No ❑ Yes, Age: _____ Rubeola: ❑ No ❑ Yes, Age: _____

Whooping Cough: ❑ No ❑ Yes, Age: _____ Other: ❑ No ❑ Yes, 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.

Patient Name:_____ Parent/Guardian Name:_____

Signed: _____ Witnessed: _____ Date: _____

(A scanned copy of this document shall serve as the original.)