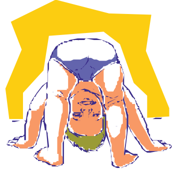
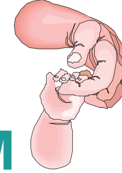


PEDIATRIC HISTORY FORM



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 Treatment:
____

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 Pain __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
Birth Intervention: ___Forceps ___Vacuum Extraction ___Caesarian Section, Emergency of 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: ________________________________
Introduction to Solids at: __________ Months, Cows' Milk at ________ Months
Food/Juice Allergies or Intolerances: _____N _____Y, List: ____

Developmental History:
During the following times you child's spine is most vulnerable to stress and should routinely be check by a doctor of chiropractic for prevention and early 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 the National Safety Council, Approximately 50% of children fall head first form 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 YOU RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to me 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: ___/___/___