

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 of contacting us: _____

Other doctors seen for this condition? ____ Yes ____ No, 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:

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

Family History: _____

Previous Chiropractor: _____

Date of Last Visit: ____/____/____ Reason: _____

Name of Pediatrician: _____

Date of Last Visit: ____/____/____ Reason: _____

Are you satisfied with the care that your child received there? ____ Yes ____ No

Number of doses of antibiotics your child has taken:

During the past 6 months: _____ Total during His/ Her Lifetime: _____

Number of doses of other prescriptions medication your child has taken:

During the past 6 months: _____ Total during His/ Her Lifetime: _____

Vaccination History: _____

PRENATAL HISTORY:

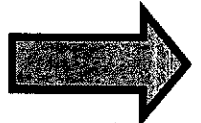
Name of Obstetrician/ Housewife: _____

Complications during pregnancy: ____ Yes ____ No List: _____

Ultrasounds during pregnancy: ____ Yes ____ No Number: _____

Medications during pregnancy/ Delivery: : ____ Yes ____ No List: _____

Cigarette/ Alcohol use during pregnancy: : ____ Yes ____ No



Location of Birth: _____ Hospital _____ Birthing Center _____ Home
 Birth Intervention: _____ Forceps _____ Vacuum Extraction _____ Ceasarian (Emergency or Planned?)
 Complications during deliver? _____ Yes _____ No List: _____
 Genetic Disorders or Disabilities: _____ Yes _____ No List: _____
 Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____
FEDDING HISTORY:
 Breast Fed: _____ Yes _____ No How Long? _____
 Formula Fed: _____ Yes _____ No How Long? _____ Type: _____
 Introduced to Solids at: _____ months, Cow's Milk at _____ months
 Food/ Juice Allergies: _____ Yes _____ No List: _____

DEVELOPMENTAL HISTORY:

During the following times your child's spine most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxations (spinal nerve interface). 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, Stairs) Was this the case with your child? _____ Yes _____ No

Is/ has your child been involved in any high impact of contact sports (i.e. Soccer, Football, Gymnastics, Baseball, Dance, 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? _____

Prior Surgery? _____ Yes _____ No List: _____

Menarche: _____ Yes _____ No List: _____

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 YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I herby 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: _____