

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: ____ / ____ / ____ Parent 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 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"/> Asthma / Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Recurring Fever | <input type="checkbox"/> Growing / Back Pains |
| <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 your child has received there? _____ N _____ Y

Number of Doses of Antibiotics you 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: _____

Ultrasound 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 information: _____ 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: _____

Introduction to solids at: _____ Months. Cows Milk at _____ Months

Food / Juice Allergies or intolerances _____ N _____ Y. List: _____

Developmental History:

Did your child use a walker/exersaucer? _____ N _____ Y.

If yes: At what age? _____ For how long? _____ How many hours per day? _____

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. List _____

Has your child been seen on an emergency basis? _____ N _____ Y. List _____

Other trauma not described above? _____ N _____ Y. List _____

Prior surgery. _____ N _____ Y. List _____

Menstrual cycle. _____ N _____ Y. Age: _____

Childhood Diseases:

Chicken Pox _____ N / Y Age _____ Mumps _____ N / Y Age _____

Rubella _____ N / Y Age _____ Whooping Cough _____ N / Y Age _____

Rubeola/Roseola _____ 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.

It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain property of this office, being on file where they may be seen at any time while a patient at this office.

Signed: _____ Witnessed: _____ Date: _____