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: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (Home) _____ (Work) _____ (Pgr./Voice) _____

Birth Date: _____ Age: _____ Sex: _____ Weight: _____ Height: _____

Referred by: _____ Names of Parents/Guardians: _____

Purpose for Contacting Us: _____

Have you seen other doctors for this condition? Yes No

Doctors' names and prior treatments: _____

_____

Other health problems: _____

Check **any** of the following conditions your child has suffered from:

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 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? Yes No

Number of doses of **Antibiotics** your child has taken: in the past 6 months: _____ Lifetime: _____

Number of doses of **Other Rx Medications** your child has taken: in the past 6 months: _____ Lifetime: _____

List: _____

Vaccination History: _____

Prenatal History

Name of Obstetrician/Midwife: _____

Complications during pregnancy? Yes No List: _____

Ultrasounds during pregnancy? Yes No Number: _____

(over)

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 C-section.....Emergency or Planned?

Complications during delivery? Yes No List: _____

Genetic disorders or disabilities? Yes No List: _____

Birth weight: _____ Birth length: _____ APGAR scores: _____ , _____

Feeding 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 or intolerances? Yes No 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 early detection of vertebral subluxation (spinal nerve interference). At what age was your child **first able to:**

_____ Respond to sound
_____ Respond to visual stimuli
_____ Hold up head
_____ Sit up
_____ Cross crawl
_____ Stand alone
_____ Walk alone

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? Yes No

Is/has your child been **involved in any high impact or contact type sports** (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? Yes No List: _____

_____

Has your child ever been involved in a **car accident**? Yes No List: _____

Has your child ever been seen on an **emergency** basis? Yes No List: _____

Other **traumas** not described above: _____

Prior **surgery**? Yes No List: _____

Menarche (females only)? Yes No Age: _____

Childhood diseases:

Chicken pox	Y / N, Age ____	Mumps	Y / N, Age ____
Rubella	Y / N, Age ____	Whooping Cough	Y / N, Age ____
Measles	Y / N, Age ____	Other	Y / N, 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 in this office.

Signed: _____ Date: _____