Pediatric History

Dear New Patient's Parent or Guardian,
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: ______________________________

Birth Date: __________ Age: ___________ Gender: ___________ Weight: _____ Height: _____

Names of Parents/Guardians: ______________________________

Address: ____________________ City: ____________ State: _____ Zip: ________

Phone: ____________________ Email: ____________________

Present Complaint

Purpose for Visit: ______________________________

Have you seen other doctors for this condition? YES NO

Prior treatments and doctors' names: ______________________________

Other Health Problems: ______________________________

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Circle **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	Motor Vehicle Accident	Temper Tantrums	Other: ________

Family History: ______________________________

Previous Chiropractor: ______________________________

Date of Last Visit: ________________ Reason: ________________

Name of Pediatrician: ______________________________

Date of Last Visit: ________________ Reason: ________________

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: ____________________ Date of Last Vaccination: ________

Prenatal History

Name of Obstetrician/Midwife: ______________________________

Complications during pregnancy? YES NO Explain: ______________________________

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 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 allergies or intolerances? YES NO List: ______________________________

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We are here to serve you, and encourage you to ask questions and express concerns. Your participation is vital, and will help determine your child's results. If you have any remaining questions, concerns, or information that this form did not cover, please use this space to write that:

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Authorization for Care of Minor

I hereby authorize this office and its doctors to administer care to my child as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees in this office.

Patient Name: ______________________________

Name of Patients' Parent or Guardian: ______________________________

Signature of Parent or Guardian: ______________________________

Date: ______________________________