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: _____

Address: _____ City: _____

State: _____Zip:_____Phone (H): _____(C):_____

Birth Date: _____/_____/_____ Sex: ☐ Male ☐ Female Weight: _____Height: _____

Name of Parents/Guardians: _____ Work #: _____

Referred By: _____

Purpose for contacting us? _____

Other Doctors seen for this condition: ☐No ☐Yes If yes, Doctor's names and Prior Treatments: _____
_____
_____

Other Health Problems? _____

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

☐ Ear Infections	☐ Scoliosis	☐ Seizures	☐ Chronic Colds	☐ Sleep Disturbances
☐ Asthma/Allergies	☐ Digestive Problems	☐ ADHD	☐ Recurring Fevers	☐ Growing Pains
☐ Colic	☐ Bed Wetting	☐ Headaches	☐ Temper Tantrums	☐ Neck/Back Pains

☐ Other: _____

Family History: _____

Previous Chiropractic Care: ☐ No ☐Yes Chiropractor Name: _____

Date of last visit: ____/____/____ Reason: _____

Name of Pediatrician: _____

Date of last visit: ____/____/____ Reason: _____

Are you satisfied with the care your child has received there? ☐ No ☐ Yes

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 of medications: _____

Vaccination History: _____

Prenatal History:

Complications during pregnancy? ☐ No ☐Yes List: _____

Ultrasounds during pregnancy? ☐No ☐ Yes #: _____

Medications during pregnancy/delivery? ☐ No ☐ Yes List: _____

Cigarette/Alcohol use during pregnancy? ☐ No ☐ Yes

Location of birth: ☐ Hospital ☐ Birthing Center ☐ Home

Birth Intervention: ☐Induced ☐ Forceps/Vacuum Extraction ☐ Caesarean Section: Emergency or Planned?

Complications during delivery? ☐ No ☐ Yes List: _____

Genetic Disorders or Disabilities? ☐ No ☐ Yes List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

Feeding History:

Breast Fed: ☐ No ☐ Yes How long: _____

Formula Fed: ☐ No ☐ Yes How long: _____

Introduced to solids at: _____ months Cow's milk at _____ months

Food Allergies or Intolerance: ☐ No ☐ Yes List: _____

Development 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 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, downstairs, etc.) Was this the case with your child? ☐ No ☐ Yes

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

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

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

Other traumas not described by above? ☐ No ☐ Yes List: _____

Prior Surgery? ☐ No ☐ Yes List: _____

Menarche? ☐No ☐ Yes Age: _____

Childhood Diseases:

Chicken Pox: ☐ No ☐ Yes Age: _____ Mumps: ☐ No ☐ Yes Age: _____
Rubella: ☐ No ☐ Yes Age: _____ Measles: ☐No ☐ Yes Age: _____
Whooping Cough: ☐ No ☐ Yes Age: _____ Other: _____