

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.#: _____
Names of Parents/Gaurdians: _____ Siblings: _____
Address: _____ City: _____
State: _____ Zip: _____ Home Phone: _____ Cell: _____
Birth Date: _____ / _____ / _____ Work Phone: _____
Sex: _____ Weight: _____ Height: _____ Referred By: _____
Would you like us to email you on periodic health articles? ___Y___ N Email: _____

Purpose for contacting us? _____

Other Doctors seen for this condition? ___Y___ N

Doctors names and prior treatments: _____

Other health problems? _____

Check any of the following conditions your child has suffered from during the past six months:

Ear Infections	Scoliosis	Seizures	Chronic Colds	Headaches
Asthma/Allergies	Digestive Problems	ADHD	Recurring Fevers	Growing/Back Pains
Colic	Bed Wetting	Car Accident	Temper Tantrums	Acid Reflux

Other _____

Previous Chiropractor: _____ Frequency of visits: _____

Date of last visit: _____ Reason: _____

Name of Pediatrician: _____ Frequency of visits: _____

Date of last visit: _____ Reason: _____

Number of doses of Antibiotics your child has taken:

During past six months: _____ Total during lifetime: _____

Number of doses of Other Prescription Medications your child has taken:

During past six months: _____ Total during lifetime: _____

List: _____

Vaccination History: _____ Any reactions? _____

Have you withheld any Vaccines? _____ Why? _____

Prenatal History:

Name of Obstetrician/Midwife: _____

Complications During Pregnancy? ___Y___ N List: _____

Ultrasounds During Pregnancy? ___Y___ N Number: _____

Medications During Prgnancy/Delivary? ___Y___ N List: _____

Cigarette/Alcohol Use During Pregnancy? ___Y___ N

Location of Birth: _____ Hospital _____ Birthing Center _____ Home

Birth Intervention _____ Forceps _____ Vacuum Extraction _____
_____ Cesarean Section, Emergency or Planned?
Complications during delivery? _____ Y _____ N List _____
Genetic disorders or disabilities _____ Y _____ N List _____
Birth Weight: _____ Birth Length: _____ Apgar Scores _____ , _____

Feeding History:

Breast fed: _____ Y _____ N , How long: _____
Formula fed: _____ Y _____ N , How long: _____ Type: _____
Introduced to solids at: _____ Months, Cow's Milk at _____ Months
Food/Juice Allergies or Intolerances: _____ Y _____ N , List: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic 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, down stairs, etc.). Was this the case with your child? _____ Y _____ N

Is/Has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? _____ Y _____ N, List _____

Do you own a trampoline? _____ Y _____ N
Has your child ever been involved in a car accident? _____ Y _____ N, List _____
Has your child ever been seen on an Emergency basis? _____ Y _____ N, List _____
Other Traumas not described above? _____ Y _____ N, List _____
Prior surgery: _____ Y _____ N, List _____

**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.

Signed: _____
Witnessed: _____
Dated: _____ / _____ / _____