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: _____ SSN: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Birth Date: _____ Work Phone: _____ Cell 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:

__ 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: ____ N ____ Y

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: _____

Vaccination History: _____

PreNatal History:

Name of Obstetrician / Midwife: _____

Complications During Pregnancy: _____ N _____ Y, List: _____

Ultrasounds 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 Intervention: _____ Foreceps _____ 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: _____

Introduced to Solids at:_____ months, Cows' Milk at _____ Months

Food / Juice Allergies or Intolerances: _____ N _____ Y , 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

_____ Respond to Visual Stimuli

_____ Hold Head Up

_____ 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? _____ N _____ Y

Is / has your child been involved in any high impact or contact typ 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 Traumas Not Described Above? _____ N _____ Y , List: _____

Prior Surgery: _____ N _____ Y , List: _____

Menarche: _____ N _____ Y , Age: _____

Childhood Diseases:

Chicken Pox	N / Y, Age _____	Mumps	N / Y, Age _____
Rubella	N / Y, Age _____	Whooping Cough	N / Y, Age _____
Rubeola	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.

Name of Insurance Company: _____ Policy #: _____

Signed: _____ Witnessed: _____ Date: _____