



# 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.#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Work 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:

- |   |   |                                       |   |   |
|---|---|---------------------------------------|---|---|
| <input type="checkbox"/> Ear Infections     | <input type="checkbox"/> Scoliosis          | <input type="checkbox"/> Seizures     | <input type="checkbox"/> Chronic Colds    | <input type="checkbox"/> Headaches            |
| <input type="checkbox"/> Asthma / Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD         | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Growing / Back Pains |
| <input type="checkbox"/> Colic              | <input type="checkbox"/> Bed Wetting        | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Temper Tantrums  | <input type="checkbox"/> 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: \_\_\_\_\_ List: \_\_\_\_\_

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: \_\_\_\_\_ Forceps \_\_\_\_\_ 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          | _____ 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 ? \_\_\_\_\_ N \_\_\_\_\_ Y

Is / has your child been involved in any high impact or contact type 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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_