Pediatric History Form

Dear New Patient,

It is a pleasure to welcome you 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:

____ Ear Infections	____ Scoliosis	____ Seizures	____ Chronic Colds	____ Headaches
____ Asthma/Allergies	____ Digestive Problems	____ ADHD	____ Recurring Fevers	____ Growing/ Back Pains
____ Colic	____ Bed Wetting	____ Car Accident	____ Injuries/ Falls	____ 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 Courses 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_____
Vaccinations Completed? _____N _____Y
On Schedule with Pediatricians Recommended Vaccinations? _____N _____Y
Not Vaccinated _____

Prenatal History

Name of Obstetrician / Midwife: _____
Complications During Pregnancy? _____N _____Y, List_____
Ultrasounds During Pregnancy? _____N _____Y, Number_____
Medications During Pregnancy? _____N _____Y, List_____
Cigarette /Alcohol Use During Pregnancy: _____N _____Y
Location of Birth: _____ Hospital _____Birthing Center _____ Home
Birth Interventions: _____Forceps _____Vacuum Extraction _____Cesarian Section, Emergency Or Planned
Complications During Delivery? _____N _____Y, List_____

Genetic Weight 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 you child's spine is the 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 _____ Sit Up _____ Walk Alone
_____ Respond to Visual Stimuli _____ Cross Crawl
_____ Hold Head Up _____ Stand Alone

According to the National Safety Council, approximately 50% of children fall 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 If yes, please describe_____
Is / has your child been involved in any high impact or contact sports
(i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.) ? _____N _____Y, List_____
Has Your Child Ever Been 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 _____	Rubella	N / Y, Age _____
Mumps	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: _____/_____/_____