Pediatric History Form

Dear New Patient,

It is a pleasure to welcome you to our family of happy 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 Name and Prior Treatments: _____
_____

Other Health Problems? _____

Check and of the Following Conditions Your Child as suffered from During the Past Six Months:

___ Ear Infections ___ Scoliosis ____ Seizures __ Chronic Colds ___ Headaches ____ ADHD

___ Asthma/Allergies ___ Digestive Problems ___ Growing/Back Pains ___ Recurring Fever

___ Temper Tantrums ___ Car Accident ___ Colic ___ 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 6 Months: ___ Total During his/her Lifetime ___ List: _____

Vaccination History: _____

Prenatal History

Name of Obstetrician/Midwife: _____

Complications during Pregnancy? ___ N ___ Y, List _____

Ultrasound during Pregnancy? ___ N ___ Y, List _____

Medications during Pregnancy ___ N ___ Y, List _____

Cigarette/Alcohol Use during Pregnancy: ___ N ___ Y, Location of Birth: ____ Hospital ____ Birthing Center ____ Home
Birth Intervention: _____ Forceps _____ Vacuum Extraction _____ Caesarean Section_____
Emergency or Planned _____

Complications during Pregnancy? _____ N _____ Y, List _____

Genetic Disorders or Disabilities? _____ N _____ Y, List _____

Birth Weight: _____ Birth Length: _____ APGAR Acores: _____, _____

Feeding History:

Breast Fed: _____ N _____ Y Formula Fed: _____N _____ Y

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 venerable 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 Sit Up _____

_____ Walk Alone _____ Stand Alone _____ Hold Head Up

According to the National Safety Council, Approximately 50% of children fall head first from a high place during their first year life (i.e. bed, changing table, down stairs) Was this the case with your child? _____ N _____Y

Is / Has your child been involved in any high impact or contact sports (i.e. Football, Gymnastics, Basketball)

_____ 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: _____

Prior Surgery: ___ N ___ Y List _____ Menarche: ___ N ___ Y Age:_____

Childhood Diseases

Chicken Pox N/Y Age ___ Mumps N/Y Age ___ Rubella N/Y Age ___ Rubella N/Y Age ___
Whooping Cough N/Y Age ___ Rubeloa N/Y Age ___ Other _____

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 A 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: ___/___/___