PEDIATRIC HISTORY FORM

Dear New Patient,
It is our 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 / Gauradians:_____

Purpose For Contacting Us? _____

Other doctors seen for this condition: _____No _____Yes; 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 ___ADHD ___Recurring fevers ___Colic __Growing/Back Pain
___Bed wetting ___Car Accident ___Digestive Problems ___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 which your child has received there? _____No ____Yes

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? ____No ____Yes; List:_____

Ultrasounds during pregnancy? _____No _____Yes; Number:_____

Medications during pregnancy / delivery? ____No _____Yes; List:_____

Cigarette / Alcohol use during pregnancy? ____No ____Yes

Location of Birth: _____Hospital _____Birthing Center _____Home _____Other:_____

Birth Intervention: _____Forceps ____Vacuum Extraction

_____Ceasarian Section : emergency or planned (please circle)

Complications during delivery? _____No _____Yes List:_____

Genetic Disorders or Disabilities: _____No _____Yes List:_____

Birth Weight:_____ Birth Length:_____ APGAR Scores:_____, _____

Was delivery within 2 weeks of due date? _____Yes _____No # of days premature / late:_____

Feeding History:

Breast fed: _____No _____Yes How long?_____

Formula fed: _____No _____Yes How long?_____ Type:_____

Introduced to solids at: _____months; Cow's Milk at _____months

Food / Juice Allergies or Intolerances: _____No _____Yes List:_____

_____

Developmental History:

During the following times your child 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 1st year of life (i.e. a bed, changing table, stairs, etc.) Was this the case with your child? ___No ___Yes

Is / Has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.) _____No _____Yes List:_____

Has your child ever been involved in a car accident? _____No ____Yes List:_____

Has your child been seen on an emergency basis? ____No ____Yes List:_____

Other traumas not described above? ____No ____Yes List:_____

Prior surgery: ____No ____Yes List:_____

Menarche: _____No _____Yes 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 for 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: _____ Relationship to patient:_____ Date:_____/_____/_____