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:_____ Home Phone:_____ S.S.#:_____

Address:_____ City:_____ State:_____ Zip:_____

Age:_____ Birth Date:_____ Sex:_____ Referred By:_____

Names of Parents/Guardians:_____ Work Phone:_____

Purpose For Contacting Us? ❑Optimal Health Check-up ❑Specific Health Concern or Challenge

Please Explain:_____

Other Doctors Seen for this Condition: ____N ____Y Doctors' Names and Prior Treatments:_____

_____

Other Health Problems? _____

Circle 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
Car Accident	Bed Wetting	Colic	Temper Tantrums	Other_____

Family History:_____

Previous Chiropractor:_____ Date of Last Visit:_____

Name of Pediatrician:_____ Date of Last Visit:_____

Reason:_____

Number of Doses of Antibiotics Your Child has Taken:

During the Past Six Months:_____ Total During His/Her Lifetime:_____

Umber of Doses of Other Prescription Medications Your Child has Taken:

During the Past Six Months:_____ Total During His/Her Lifetime:_____

Vaccination History:_____

Adverse Reactions: ❑Fever ❑High Pitched Screaming ❑Redness at Injection Site ❑Seizure ❑Lethargy ❑Diarrhea ❑Other

Prenatal History:

Name of Obstetrician / Midwife:_____

Complications During Pregnancy? ____N ____Y List:_____

Ultrasounds During Pregnancy? ____N ____Y Number:_____ Cigarette/Alcohol Use During Pregnancy? ____N ____Y

Medications During Pregnancy/Delivery? ____N ____Y List:_____

Location of Birth: ____Home ____Birthing Center____Hospital ____Other

Birth Intervention: ____Forceps ____Vacuum Extraction ____Caesarian Section, Emergency or Planned? ____None

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? _____ Difficulties? ____N ____Y

Formula Fed? ____N ____Y How Long? _____ Type:_____

Does Your Child Consume: ____Cow's Milk ____Meat (including chicken) ____Fish Introduced to Solids at:_____Months

Food / Juice Allergies or Intolerances: ____N ____Y List:_____

_____

Developmental History:

During the following times your child's Nervous System & Spine are 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 _____Hold Head Up _____Sit Up

_____Cross Crawl _____Stand Alone _____Walk Alone

_____Respond to Visual Stimuli

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:_____

What other hobbies or activities does your child participate in? _____

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:_____

Has Your Child Ever Suffered Broken Bones? ____N ____Y Concussion? ____N ____Y Bloody Nose? ____N ____Y

Other Traumas Not Described Above? ____N ____Y List:_____

Prior Surgery: ____N ____Y List:_____

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_____

Do You Feel Your Child is as Healthy as He / She Could Be? ____N ____Y

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:_____ Date:_____ Witnessed:_____