Pediatric History Form

Date: ________

Name: ___________________________________S.S.#____________________________
Birth Date: _____________ Sex: _______ Weight: _________
Address: ____ City: ______________________
State: ____ Zip: ______________ Home Phone: ___________________________
Names of Parents/Guardians:
____
Referred By: ____
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 ___Bed Wetting
___Chronic Colds ___Seizures ___Growing/Back Pains
___Headaches ___Asthma/Allergies ___Digestive Problems
___ADHD ___Temper Tantrums ___Car Accident
___Recurring Fevers ___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? ___No ___Yes

Number 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
Birth Intervention:
___Forceps ___Vacuum Extraction ___C- Section, Emergency or Planned?
Complications During Delivery: ___No ___Yes List:____________________________
Genetic Disorders of Disabilities: ___No ___Yes
Birth Weight: _____ Birth Length: _____ Apgar Scores: _____

Feeding History:
Breast Fed: ___No ___Yes How Long? _______
Formula Fed: ___No ___Yes How Long? _______ Type: __________________________
Introduced to Solids at: ________ Months Cows Milk at ________ Months
Food/Juice Allergies or Intolerances: ___No ___ Yes List: ________________________

Developmental History:
During the following times your child 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
____ 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 first year of life, (I.e. a bed, changing table, down 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 Ever Been Seen on an Emergency Basis? ___ No ___ Yes
List: ____
Other Traumas Not Described Above ___No ___Yes List: ____________________
Prior Surgery: ___ No ___ Yes List: ____________________________________
Menstruation: ___ 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 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: ________________________ Witnesses: ___________ Date: ______________