

Pediatric History Form

Date: _____

Name: _____ Address: _____

City, State, Zip: _____ Home Phone: _____

D.O.B.: _____ Sex: _____ Weight: _____ Height: _____

Name of Parents/Guardians: _____

Referred By: _____

Purpose for Contacting us? _____

Other Doctors seen for this condition? No Yes (Name: _____)

Other Health Conditions? _____

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
Colic	Bed Wetting	Car Accident	Temper Tantrums	Other: _____

Previous Chiropractor: _____ Date of Last Visit: ____/____/____

Reason: _____

Name of Pediatrician: _____ Date of Last Visit: ____/____/____

Reason: _____

Number of doses of antibiotics your child has taken?

During the past 6 months: _____, Total during his/her lifetime: _____

Number of other doses of other prescription medications:

During the past 6 months: _____, Total during his/her lifetime: _____ List: _____

Vaccination History: _____

Prenatal History

Complications during pregnancy? No Yes (_____)

Ultrasounds during pregnancy? No Yes (_____)

Medications during pregnancy/delivery? No Yes (_____)

Cigarette/Alcohol use during pregnancy? No Yes

Name of Obstetrician/Midwife: _____ Location of birth: Home Birthing Center Hospital

Birth Intervention(s): Forceps Vacuum Extraction Caesarian Section(emergency or planned?)

Complications during delivery? No Yes Genetic disorders or disabilities? No Yes

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

Feeding History

Breast fed: No Yes (How Long: _____)
Formula fed: No Yes (How Long: _____)

Introduced to **solids** at _____ months, **cow's milk** at _____ months

Food/Juice Allergies or Intolerances:

No Yes (_____)

Developmental History

During the following times your child's 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	_____ Cross Crawl
_____ Respond to Visual Stimuli	_____ Stand Alone
_____ Hold Head Up	_____ Walk Alone
_____ Sit Up	

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, stairs, etc.) **Was this the case with your child?** No Yes

Is/Has your child been involved in any high impact or contact sports (I.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, etc) ? No Yes (_____)

Has your child ever been involved in a car accident? No Yes (_____)

Has your child been seen on an emergency basis? No Yes (_____)

Other Traumas not described above? _____

Prior Surgery: No Yes (_____)

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 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.

Signed: _____

Date: ____/____/____

Witnessed: _____

Date: ____/____/____