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__________________________________ SS#____________________

Name of Parents / Guardians______________________________________

Address____City________________State_________Zip__________

Home Phone______________ ______ Parent Work Phone___________________ Parent Email:___________________________

Patient Birth Date ___/____/____ Sex______ Weight___________ Height_______ Number of siblings_______

How did you hear about our office? ____

Reason for seeking chiropractic care:____

Other Doctors seen for this condition ____N ____Y

Dr.'s Name and prior treatment ____

Other Health Problems____

Has your child ever suffered from: (Check all that apply)

☐ Dizziness	☐ Backaches	☐ Heart trouble	☐ Chronic earaches
☐ Diabetes	☐ Tuberculosis	☐ Hypertension	☐ Colds / Flu
☐ Arthritis	☐ Headaches	☐ Asthma	☐ Allergies
☐ Neuritis	☐ Digestive Disorders	☐ Sinus trouble	☐ Constipation
☐ Anemia	☐ Rheumatic Fever	☐ Orthopedic problems	☐ Diarrhea
☐ Poor Appetite	☐ Hyperactivity	☐ Sugar concentration	☐ Behavioral problems
☐ Bed Wetting	☐ Convulsions	☐ Paralysis	☐ Muscle jerking
☐ Fainting	☐ Walking problems	☐ Broken bones	☐ Ruptures / Hernias
☐ Neck Problems	☐ Arm problems	☐ Leg problems	☐ "Growing pains"
☐ Joint Problems	☐ Blood disorders	☐ Stomach aches	☐ Other______________

Family Health History: ____

Previous Chiropractor: _______________________________________ Date of last visit ___/___/___

Reason: ____

Name of Pediatrician: _______________________________________ Date of last visit ___/___/____

Reason: ____

Are you satisfied with the care your child received there? ____N ____Y

Number of doses of antibiotics your child has taken:

During the past 6 months____ Total during his/her lifetime____

Number of doses of other prescription medications your child has taken:

During the past 6 months____ Total during his/her lifetime____

Vaccination history____

Prenatal History

Type of Birth Attendant: OBGYN CNM Lay Midwife Name of attendant: ____________________________

Location of Birth: _____Home _____Birthing Center _____Hospital

Complications during pregnancy: ____N ____Y List: ____

Ultrasounds during pregnancy: ____N ____Y Number: __________

Medications during pregnancy / delivery: ____N ____Y List: ____

Cigarette / Alcohol use during pregnancy: ____N ____Y

Birth intervention: _____Forceps _____Vacuum _____Caesarian: Planned or Emergency _______________

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?___________ Formula fed: ____N ____Y How long?___________

Type:_____________ Introduced to solids at _____ months, Cow's milk at _____ months

Food / juice allergies or intolerances ___N ___Y List: ____________________________________

Developmental History

Number of hours sleeping per night: __________ Quality of sleep: Good Fair Poor

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? ____N ____Y

Is / has your child been involved in any high impact or contact type sports? ___N ___Y Type: ________________

Has your child ever been involved in a car accident? ___N ___Y Date:_____________________________

Has your child been seen on an emergency basis? ___N ___Y Reason and Date: ___________________________________

Other traumas not described above? ___N ___Y Date: _____________________________

Prior surgery: ___N ___Y Type and Date:________________________________ Menarche: ___N ___Y 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 _______

Insurance

Do you have medical insurance? ____N ____Y Insurance Company Name ________________________________

Policy Number ____________________________Insurance Company Phone number ________________________

Insured's Name ____________________________Relationship to patient _________________________________

Insured's DOB ____________________________Insured's SS# ____

Insured's Employer ________________________ Insured's Employee Address______________________________

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 __________________________________Witnessed ______________________________________Date: ___/___/___