

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 a better health for your family.

Patient Name: _____ S.S.# _____

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

Birth date: ____/____/____ Weight: _____ Height: _____

Name of Parents/Guardians _____ Home Phone: _____

Parents Work Phone: _____ Parents Cell Phone: _____

Purpose for contacting us? _____

Other doctors seen fir this condition: Y____ N____ - Doctor's names and prior treatments: _____

Other health problems: _____

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? Y____ N____

Number of doses of **ANTIBIOTICS** your child has taken...

During the last 6 months _____ Total during his/her life _____

Number of doses of **OTHER PRESCRIPTION MEDICATION** your child has taken...

During the last 6 months _____ Total during his/her life _____

Vaccination History: _____

PRENATAL HISTORY

Name of Obstetrician/Midwife: _____

Complications during pregnancy? Y____ N____ List: _____

Complications during delivery? Y____ N____ List: _____

Ultrasounds during pregnancy? Y____ N____ Number: _____

Medications during pregnancy/delivery ? Y____ N____ List: _____

Location of birth: Hospital _____ Birthing Center _____ Home _____

Birth intervention: ____Forceps ____Vacuum extraction ____Cesarean Section (____Emergency ____Planned)

APGAR Scores: _____, _____ Cigarette/Alcohol use during pregnancy? Y____ N____

Genetic disorders or disabilities? Y_____ N_____ List: _____

Birth Weight: _____ Birth Length: _____

FEEDING HISTORY

Breastfed? Y_____ N_____ How long? _____ Formula fed? Y_____ N_____ How Long? _____

Introduced: Solids at _____ months Cows milk at _____ months

Any food or juice allergies? Y_____ N_____ List: _____

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 up head _____ Walk alone
_____ Sit up

According to the National Safety Council, approximately 50% of children fall from a high place during the first year of life (i.e. bed, changing table, down stairs, etc.). Was this the case with your child? Y_____ N_____ List: _____

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

Has your child ever been involved in a car accident? Y_____ N_____ List: _____

Has your child ever been seen on an emergency basis? Y_____ N_____ List: _____

Other traumas not listed? Y_____ N_____ List: _____

Prior surgery? Y_____ N_____ List: _____

Menarche: Y_____ N_____ Age: _____

CHILDHOOD DISEASES

Chicken Pox:	Y_____ N_____ Age: _____	Mumps:	Y_____ N_____ Age: _____
Rubella:	Y_____ N_____ Age: _____	Whooping Cough:	Y_____ N_____ Age: _____
Rubeola:	Y_____ N_____ Age: _____	Other:	Y_____ N_____ Age: _____

**WE ARE HERE TO SERVE YOU AND TO 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 child 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 Co.: _____ Policy #: _____

Signature of Parent/Guardian: _____ Date: _____

Witness: _____