

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 _____ Email Address _____

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)

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