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: _____S.S.#: _____

Address _____City:_____

State: _____ Zip: _____Home Phone: _____

Birth Date: ____/____/____Work Phone: _____

Sex: _____Weight: _____Height: _____Referred By: _____

Names of Parents/Guardians: _____

Purpose For Contacting Us? _____

Other doctors seen for this condition: ____N____Y, Doctors' names and prior treatments: _____

_____

Other health problems? _____

Check any of the following conditions your child ha 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_____

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 received there?____N____Y

Number of doses 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? ____N____Y, List: _____

Ultrasounds during pregnancy? ____N____Y, Number: ____

Medications during pregnancy/delivery? ____N____Y, List: _____

Cigarette/alcohol use during pregnancy: ____N____Y

Location of birth:____Hospital, ____Birthing Center, ____Home

Birth Intervention: ____Forceps, ____Vacuum Extraction, ____Cesarian section, Emergency or Planned?

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, Cows' Milk at _____ Months

Food/Juice allergies or intolerances: ____N____Y, 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
_____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 (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ____N____Y, List: _____

Has your child ever been involved in a car accident? ____N____Y, List: _____

Has your child been seen on an emergency basis? ____N____Y, List: _____

Other traumas not described above? ____N____Y, List: _____

Prior Surgery: ____N____Y, List: _____

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 ____

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: _____ Witnessed: _____ Date: ____/____/____