Whom may we thank for referring you to our office? _____

SCHOENHERR CHIROPRACTIC, INC

PEDIATRIC HISTORY FORM

Stephen Schoenherr, DC
1365 Triad Center Drive, Suite B
St. Peters, MO 63376

Today's Date _____/_____/_____

Name_____ Date of Birth _____/_____/_____ Social Security # _____-_____-_____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ Mothers mobile: _____Fathers mobile: _____

Mother_____ DOB_____/_____/_____Father _____DOB_____/_____/_____

Pediatrician/Family MD _____City & State _____ Last Visit: ____/____/____

Purpose of last visit _____

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____ Age: _____

Ever been under chiropractic care? ☐ No ☐ Yes: Who/When? _____

Who is responsible for this bill? ☐ Mother ☐ Father ☐ Other *(please explain)* _____

Insurance Company _____

PREGNANCY HISTORY:

Third Trimester Presentation: _____Vertex _____Breech _____Transverse _____Face/Brow

Type of Birth: _____Normal Vaginal _____Forceps _____Cesarean _____Suction Cap or Vacuum

Location: _____Home _____Hospital _____Birthing Center _____Other:_____

Problems during Pregnancy: _____

Problems during Labor/Delivery: _____

Was there presence of: _____Jaundice? (Yellow) _____Cyanosis? (Blue) _____Congenital Anomalies/Defects?

*If yes, please explain*_____

INFANT HISTORY:

Infant feeding: _____Breast _____Bottle If Bottle; which Formula? _____

Number of Hours sleep per night _____ Quality of Sleep: _____Good _____Fair _____Poor

List all **IMMUNIZATIONS** you child has had**:** _____

Has your child ever been treated at the emergency room? _____ If yes; please explain _____

Has your child ever been hospitalized? _____ If yes; please explain _____

Has your child ever had any Surgeries? _____ If yes; please explain _____

Is your child currently on any medication? _____ If yes; please list: _____

AT WHAT AGE DID THE CHILD:

Respond to sound_____ Follow an object with his/her eyes_____ Hold heel up_____
Sit Alone_____ Crawl_____ Stand_____ Walk alone_____

AT WHAT AGE, IF EVER, DID CHILD SUFFER FROM THE FOLLOWING:

Chicken pox_____ Mumps_____ Measles_____ Rubella_____
Whooping Cough_____ Other: _____

HAS YOUR CHILD EVER SUFFERED FROM:

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Allergies to_____
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Allergies to_____
☐ Asthma	☐ Scoliosis	☐ Anemia	☐ Allergies to_____
☐ Colds/Flu	☐ Walking Trouble	☐ Bed Wetting	☐ Other: _____
☐ Colic	☐ Broken Bones	☐ Sleeping Problems	☐ Other: _____

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS:

☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall off skateboard or skates
☐ Fall from crib	☐ Fall off swing	☐ Fall off bicycle
☐ Fall from high chair	☐ Fall off slide	☐ Fall down stairs
☐ Fall from changing table	☐ Fall off monkey bars	☐ Other: _____

Has your child ever sustained an injury playing organized sports? _____ If yes; please explain_____

_____

Has your child ever sustained an injury in an auto accident? _____ if yes; please explain_____

_____

FAMILY HISTORY:

Please indicate if your child or a family member has had any of the following: *Write "C" for child, "F" for family member:*

____ Heart Disease	____ Diabetes	____ Stroke
____ Cancer	____ High / Low blood pressure	____ Asthma
____ Gastrointestinal disease	____ Memory/mood disorder	____ Thyroid problem

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____Wellness _____Check-up _____Other: _____

_____Pain/Discomfort; explain_____

_____Injury; explain_____

If due to Pain/Discomfort/Injury, please fill out:

1. **Onset** of Problem: Date ____/____/_____ _____Unknown _____Gradual _____Sudden
2. **Ever had** this problem **before**? ☐ No ☐ Yes If yes when? _____
3. Any **bowel or bladder** problems since this problem began?: No Yes *(Describe)*:_____
4. Any **medication taken** for this problem? No Yes: _____
5. Have you seen any **other doctors** for this problem? No Yes: _____
6. How is this problem **NOW:** ☐Rapidly Improving ☐Improving Slowly ☐About the Same ☐Gradually Worsening ☐On & Off

I understand that I am directly and fully responsible to (practice or doctors name) for all chiropractic care my child receives. It has been explained to me that all fees paid for x-rays taken at this office are for the examination, and that I am only entitled to a copy of the written imaging report, which explains the results of my child's examination. The actual films themselves are considered part of my child's original health record and as such will not be released to anyone, under any circumstances, including me. I further understand and agree that they are **the sole legal property** of this practice and that by law the doctor must retained these films for a period of no less than (__years)

I hereby authorize this office and its Doctor(s) to administer care, as they so deem necessary to my son/daughter

_____ _____Parent's or Legal

Guardian's Signature Date