Pediatric History Form

Patient Name:____SS#_________________

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, Doctor's name and prior treatments

____

____

Other health problems?____

Check any of the following conditions your child has suffered from during the past six months:

_ear infections	_scoliosis	_seizures	_chronic colds
_asthma/allergies	_digestive problems	_ADHD	_headaches
_recurring fevers	_growing/back pain	_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 has 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 prescriptions 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

Locations of birth:____hospital____birthing center____home

Birth intervention:_____forceps____vacuum extraction_____

Caesarian section:_____ emergency or ____planned?

Complications during delivery?____N____Y, List_______________________________

Genetic disorders or disabilities:____N_____Y, List_____________________________

Birth weight_______birth length_______APGAR score_____,_____

Feeding History

Breast fed:____N____Y, how long:____

Formula fed:_____N_____Y, how long:_______________________________________

Introduced to solids at:______months, Cow's milk at ______months

Food/juice allergies or intolerances:_____N_____Y, List:_________________________

Developmental History
During the following time 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 nervous system 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, (bed, changing table, down stairs). Was this the case with your child?_____N______Y

Has your child been involved in any high impact or contact type sports (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 began:_______________________________________

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__________________________________

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 a 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:____**Date**________________

Witnessed:____**Date**________________