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)

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