PEDIATRIC HISTORY FORM

Dear Parent,
It is our 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 serve you better, please complete the following information. We look forward to working with you and your family to build better health.

Patient Name: ______________________________ S.S. ____________________

Address: __________________________________ City:____________________

State: __________________ Zip: ____________ Home Phone: _______________

Birth Date: _____/_____/____ Work Phone: _______________Cell _____________

Sex: M F Weight: _________ Height: _______ Referred by: _________________

Names of Parents / Guardians: ____

Purpose for Contacting Us? ____
Other Doctors Seen for this Condition Y N Doctors' Names and Prior Treatment:
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 ()Headaches
() Asthma/Allergies () Digestive Problems () Recurring Fevers () ADHD
() Growing/back pain () Colic () Bed Wetting () Temper Tantrums () Car Accident

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 Why:? ________________

Has your child been vaccinated: Y N Age of first vaccination: ____________________

Number of doses of Antibiotics your child has taken:
During the past six months: _____________ Total during his/her lifetime: __________ List: _______

Number of Prescription medications your child has taken:
During the past six months: _____________ Total during his/her lifetime: __________ List: _______

Prenatal History:
Name of Obstetrician / Midwife: ____
Complications During Pregnancy? N Y List:_________________________________
Ultrasounds During: 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 ______ Caesarian Section _____ Emergency or Planned

Complication During Delivery? N Y, List ____

Genetic Disorders or Disabilities: Y N, List ____

Birth Weight __________ Birth Length: ________________ APGAR Score: _____________

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: ________________________________

According to the National Safety Council, approximately 50% of all children fall head first from a high place during the first year of their life (i.e. a bed, changing table, stairs, etc.) Was that true of your child? N Y Explain: ____

Is/Has your child ever been involved in any high impact or contact type sports (i.e. soccer, football gymnastics, baseball, cheerleading, martial arts) ? Y N, List:
____

Has your child ever been involved in a car accident? N Y List: ______________________________

Has your child ever been seen on an emergency basis? N Y List: _____________________________

Other Traumas not described above: N Y List? ____

Prior Surgery: N Y List: ____

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 agree this office and its Doctors to administer are to my son/daughter, as they may deem necessary. I clearly understand and agree that I am personally responsible for payment for all fees charged by this office

Name of Insurance Company: ________________________________ Policy# _____________________

Insured's Name _______________________________________Insured's Date of Birth _____________

Insured's Social Security #: ______________________________

Signed: ___________________________ Witnessed: ______________________ Date: ____________