

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 fill out the following information.

Patient Name	Address	City
State	Zip Code	Home Phone Number
		Work Phone Number
S.S. #	<input type="checkbox"/> Male or <input type="checkbox"/> Female	Height
		Weight
Names of Parents/Guardians		Birth Date
		Purpose for contacting us?

Other doctors seen for this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give doctor's name and prior treatments
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Other Health Problems?	
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Family History	
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Previous Chiropractor	Date of Last Visit	Reason
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Name of Pediatrician	Date of Last Visit	Reason
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Are you satisfied with the care your child has received there?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Number of doses of Antibiotics your child has taken:	During the past 6 months?	During his/her lifetime?
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Number of doses of Other Prescriptions your child has taken?	During the past 6 months?	During his/her lifetime?
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Vaccination History:	
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Prenatal History:

Name of Obstetrician/Midwife	Complications during pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	List:
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Complications during delivery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	List	Ultrasounds during pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How many?
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Medications during pregnancy/delivery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	List:
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Location of birth	Birth Intervention	If Cessarian Section:	<input type="checkbox"/> Emergency or <input type="checkbox"/> Planned
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APGAR scores:	Cigarette/Alcohol use during pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Birth Length	Birth Weight
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Genetic Disorders or Disabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	List:
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Feeding History:

Breast Fed? <input type="text"/>	How Long? <input type="text"/>	Formula Fed? <input type="text"/>	How long? <input type="text"/>	Type: <input type="text"/>
Introduced to solids at how many months? <input type="text"/>		Introduced to cow's milk at how many months? <input type="text"/>		

Developmental History:

During early childhood, children's spines are 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 <input type="text"/>	Respond to Visual Stimuli <input type="text"/>	Hold Head Up <input type="text"/>
	Sit up <input type="text"/>	Cross Crawl <input type="text"/>	Stand Alone <input type="text"/>
			Walk Alone <input type="text"/>

According to the National Safety Council, approximately 50% of children fall from a high place during their first year of life (i.e. bed, changing table, down stairs, etc). Was this the case with your child? Yes No

Is/Has your child been involved in any high impact or contact sports? Yes No List:

Has your child ever been in a car accident? Yes No List:

Other traumas not described above? Yes No List:

Prior Surgery: Yes No List:

Menarche: Yes No Age:

Childhood Diseases:

Please state at what age your child had any the following diseases that apply:

Chicken Pox Rubella Rubeeola Mumps Whooping Cough

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 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 #

Signature: _____ Witnesses: _____ Date: _____