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. #		☐ Male or ☐ Female		Height		Weight		Birth Date			
Names of Parents/Guardians				Purpose for contacting us?							

Other doctors seen for this condition?	☐ Yes ☐ No	If yes, give doctor's name and prior treatments									
Other Health Problems?											
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?	☐ Yes ☐ No										

Number of doses of Antibiotics your child has taken:	During the past 6 months?		During his/her lifetime?
Number of doses of Other Prescriptions your child has taken?	During the past 6 months?		During his/her lifetime?
Vaccination History:			

Prenatal History:

Name of Obstetrician/Midwife		Complications during pregnancy?	☐ Yes ☐ No	List:							
Complications during delivery?	☐ Yes ☐ No	List		Ultrasounds during pregnancy?	☐ Yes ☐ No	How many?					
Medications during pregnancy/delivery?	☐ Yes ☐ No	List:									
Location of birth		Birth Intervention		If Cessarian Section:	☐ Emergency or ☐ Planned						
APGAR scores:		Cigarette/Alcohol use during pregnancy?	☐ Yes ☐ No	Birth Length		Birth Weight					
Genetic Disorders or Disabilities?	☐ Yes ☐ No	List:									

Feeding History:

Breast Fed?		How Long?		Formula Fed?		How long?		Type:	
Introduced to solids at how many months?				Introduced to cow's milk at how many months?					

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		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 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 | Ruebella | Ruebeola | 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: _____

Submit by Email

If you have a Mac save file and email attachment