



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.

Who may we thank for referring you into our office? _____

Patient Name: _____ S.S. #: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Birthdate: ____ / ____ / ____ Sex: M / F Weight: _____ Height: _____

Names of parents / Guardians: _____

PURPOSE FOR CONTACTING US:

Other doctor's seen for this condition? YES NO

If yes, Doctor's names & Prior treatments: _____

Other health problems? _____

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 has received there? YES NO

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

Name of obstetrician/Midwife: _____

Complications during pregnancy? YES NO If yes, list: _____

Complications during delivery? YES NO If yes, list: _____

Ultrasounds during pregnancy? YES NO If yes, number: _____

Medications during pregnancy/delivery: YES NO If yes, number: _____

Location of birth: HOSPITAL BIRTHING CENTER HOME

Birth intervention: FORCEPS VACUUM EXTRACTION

CESSARIAN SECTION - EMERGENCY or PLANNED?

Apgara scores _____, _____

Cigarette/Alcohol use during pregnancy? YES NO

Genetic disorders or disabilities? YES NO If yes, list: _____

Birth Weight: _____ Birth Length: _____

FEEDING HISTORY

Breast fed? YES NO If yes, how long? _____ Formula fed? YES NO If yes, how long? _____

Introduced solids at: _____ months, cow's milk at _____ months

Food/juice allergies or intolerances? YES NO If yes, list? _____

DEVELOPMENTAL HISTORY

During the following times 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 vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to Sound _____ Cross Crawl

_____ Respond to Visual Stimuli _____ Stand Alone

_____ Sit Up _____ 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. a bed, a 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 (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? YES NO If yes, list: _____

Has your child ever been involved in a car accident? YES NO If yes, list: _____

Has your child ever been seen on an emergency basis? YES NO If yes, list: _____

Other traumas not described above? YES NO If yes, list: _____

Prior surgery? YES NO If yes, list: _____

Menarche? YES NO If yes, list: _____

CHILDHOOD DISEASES

Chicken Pox YES NO If yes, age: _____

Mumps YES NO If yes, age: _____

Rubella YES NO If yes, age: _____

Whooping Cough YES NO If yes, age: _____

Rubeola YES NO If yes, age: _____

Other YES NO If yes, age: _____

**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.

Name of Insurance Company: _____ Policy #: _____

Signed: _____

Witnessed: _____

Date: _____ / _____ / _____