

**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#: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Business: \_\_\_\_\_  
Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Referred By: \_\_\_\_\_  
Names of Parents/Guardians: \_\_\_\_\_

**Purpose for Contacting Us**

Other Doctors seen for this condition: Yes: \_\_\_\_\_ No: \_\_\_\_\_  
Doctor's Names/Prior Treatments: \_\_\_\_\_

Check any of the following conditions your child has suffered from during the past 6 months:

- Ear Infections       Scoliosis       Seizures       Chronic Colds
- Asthma/Allergies       Digestive Problems       ADHD       Recurring Fevers
- Colic       Bed Wetting       Car Accident       Temper Tantrums
- Headaches       Growing/Back Pains       Other:       Other

**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 received? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Antibiotics--Number of doses your child has taken:

In last 6 months: \_\_\_\_\_ Total during lifetime: \_\_\_\_\_

Prescription Medications--Number of doses your child has taken:

In last 6 months: \_\_\_\_\_ Total during lifetime: \_\_\_\_\_ List: \_\_\_\_\_

Vaccination History: \_\_\_\_\_

**PRENATAL HISTORY**

Name of Obstetrician/Midwife: \_\_\_\_\_

Complications during pregnancy Yes: \_\_\_\_\_ No: \_\_\_\_\_ List: \_\_\_\_\_

Ultrasounds during pregnancy Yes: \_\_\_\_\_ No: \_\_\_\_\_ #: \_\_\_\_\_

Medications during pregnancy/delivery Yes: \_\_\_\_\_ No: \_\_\_\_\_ List: \_\_\_\_\_

Cigarette/Alcohol use during pregnancy Yes: \_\_\_\_\_ No: \_\_\_\_\_

Location of Birth: Hospital \_\_\_\_\_ Birthing Center \_\_\_\_\_ Home \_\_\_\_\_

**BIRTH INTERVENTION**

Forceps \_\_\_\_\_ Vacuum Extraction \_\_\_\_\_ Caesarian Section: Planned \_\_\_\_\_ Emergency \_\_\_\_\_

Complications during Delivery? Yes: \_\_\_\_\_ No: \_\_\_\_\_ List: \_\_\_\_\_

Genetic disorders or disabilities? Yes: \_\_\_\_\_ No: \_\_\_\_\_ List: \_\_\_\_\_

**FEEDING HISTORY**

Breast Fed Yes: \_\_\_\_\_ No: \_\_\_\_\_ How Long: \_\_\_\_\_

Formula Fed Yes: \_\_\_\_\_ No: \_\_\_\_\_ How Long: \_\_\_\_\_

Introduced to solids at Month: \_\_\_\_\_ Cows Milk at Month: \_\_\_\_\_

Allergies/Intolerance Yes: \_\_\_\_\_ No: \_\_\_\_\_ List: \_\_\_\_\_

**DEVELOPMENTAL HISTORY**

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor or chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

\_\_\_\_\_ Respond to sound      \_\_\_\_\_ Hold Head Up      \_\_\_\_\_ Cross Crawl      \_\_\_\_\_ Walk Alone  
\_\_\_\_\_ Respond to Visual Stimuli      \_\_\_\_\_ Sit Up      \_\_\_\_\_ Stand Alone \_\_\_\_\_

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie, bed, changing table, down stairs, etc).

Was this the case with your child? Yes: \_\_\_\_\_ No: \_\_\_\_\_ List: \_\_\_\_\_

Is/has your child been involved in any high impact or contact type sports (ie, soccer, football, gymnastics, baseball, cheerleading, martial arts, etc)?

Yes: \_\_\_\_\_ No: \_\_\_\_\_ List: \_\_\_\_\_

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

Have your child been seen on an emergency basis? Yes: \_\_\_\_\_ No: \_\_\_\_\_ List: \_\_\_\_\_

Other traumas not described above? Yes: \_\_\_\_\_ No: \_\_\_\_\_ List: \_\_\_\_\_

Prior surgery? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Menarche? Yes: \_\_\_\_\_ No: \_\_\_\_\_ List: \_\_\_\_\_

**CHILDHOOD DISEASES**

Chicken Pox Yes: \_\_\_\_\_ No: \_\_\_\_\_ Age: \_\_\_\_\_ Rubeola Yes: \_\_\_\_\_ No: \_\_\_\_\_ Age: \_\_\_\_\_

Rubella Yes: \_\_\_\_\_ No: \_\_\_\_\_ List: \_\_\_\_\_ Mumps Yes: \_\_\_\_\_ No: \_\_\_\_\_ Age: \_\_\_\_\_

Whooping Cough Yes: \_\_\_\_\_ No: \_\_\_\_\_ List: \_\_\_\_\_ Other Yes: \_\_\_\_\_ No: \_\_\_\_\_ 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 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.

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Signed: \_\_\_\_\_ Witnessed: \_\_\_\_\_ Date: \_\_\_\_\_