PEDIATRIC HISTORY FORM

Dear New Family,

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: _____ S.S.#: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Date of Birth: _____/_____/_____ Work Phone: _____

Sex: _____ Weight: _____ Height: _____ Referred by: _____

Names of Parents / Guardians: _____

Reason for Contacting Us ? _____

Other Doctors seen for this condition?: __N__Y , Doctors' names and prior treatment: _____

_____

Additional concerns or 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/illness [ ] Headaches [ ]Torticollis
[ ] Asthma [ ] Digestive Problems [ ] ADHD [ ] Recurring Fevers [ ] Growing/ Back Pain
[ ] Neck pain [ ]Colic [ ] Bed Wetting [ ] Car accident [ ] Temper Tantrums [ ] Other_____

Family History: _____

Previous Chiropractor: _____ Date of last visit: _____/_____/_____

Reason for visits: _____

Name of Pediatrician: _____ Date of last visit: _____/_____/_____

Reason: _____

Are you satisfied with the care your child received there? ____N____Y.

Number of doses of antibiotics for your child: During the past six months:_____Total lifetime: __

Number of doses of other prescription medications your child has taken: During the past six months:____

Total lifetime: ____ List meds:_____

Vaccination History: _____

Prenatal History:

Name of Obstetrician / Midwife: _____

Complications during pregnancy?: ____N ____Y ., List: _____

Ultrasounds during pregnancy?: ____N ____Y , Number: _____

Medications during pregnancy /delivery?: ____N ____Y , List: _____

Cigarette /Alcohol use during pregnancy?: ____N ____Y

Location of Birth: _____Hospital (Specify Name) _____Birthing center ___Home.

Birth intervention?:_____ Forceps _____Vacuum extraction _____Caesarian section; Emergency or Planned?

Complications during delivery? _____N_____Y , List: _____

Genetic disorders or disabilities?: _____N_____Y , List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores(if known): _____ , _____

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 _____

Development 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	_____ Sit Up	_____ Walk Alone
_____ Respond to Visual Stimuli	_____ Cross Crawl	
_____ Hold Head 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: a bed, changing table, down stairs, etc.)
Has this happened with your child? _____N_____Y

Is / has your child been involved in any of these high impact or contact type sports? (CIRCLE) Soccer, football, gymnastics, baseball, cheerleading, martial arts, lacrosse, Others: _____

Has your child ever been involved in a car accident? _____N_____Y , Dates: _____

Has your child ever been seen on an emergency basis? _____N_____Y , List: _____

Other traumas not described above? _____N_____Y , List: _____

Surgery: _____N_____Y , List: _____

Natural Childhood Diseases:

Chicken Pox	N / Y, Age _____	Mumps	N / Y, Age _____
Rubella	N / Y, Age _____	Whooping Cough	N / Y, Age _____
Rubeola	N / Y, Age _____	Other	N / Y, Age _____

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 which are not covered by my insurance policy.

Name of Insurance Company: _____ Policy #: _____

Signed: _____ Witnessed: _____ Date: ____/____/_____