PEDIATRIC HISTORY FORM

Patient Name: ____

Address:____ City:________________________

State:_______________ Zip:____________ Home Phone:______________________________

Birth Date: _____/_______ /______ Sex:_______ Weight:__________ Height: _____________

Referred By:____

Names of Parents / Guardians:

____

Purpose For Visit

____

____

____

Other Doctors seen for this condition: No Yes If Yes, Doctors' names and treatments:

____

____

Other health problems/concerns?

____

Circle any of the following conditions your child has suffered from during the past six months:

Ear Infections Scoliosis Seizures Chronic Colds Headaches

Asthma Allergies Digestive Problems Colic Recurring Fevers ADHD

Growing / Back Pains Bed Wetting Car Accident Temper Tantrums Other _________

Family health history:

____

____

Previous Chiropractor:

____

Date of Last Visit: _____ / _____ / ______ Reason:____________________________________

Name of Pediatrician:

____

Date of Last Visit: _____ / _____ / ______ Reason: ____________________________________

Has your child in the past six months taken any antibiotics: No Yes

If Yes, please list which and explain:____

Has your child in the past six months taken other prescription medications: No Yes

If Yes, please list which and explain:__________________________________ ____________

Did you choose to have your child vaccinated? No Yes

Have you noticed any side effects or changes post-vaccination?

____

PRENATAL HISTORY:

Name of Obstetrician/Midwife: ____

Complications during pregnancy? No Yes

If Yes, list: ____

Ultrasounds during pregnancy? No Yes If Yes, number: ________________________

Medications during pregnancy/delivery? No Yes If Yes, list: ________________________

Cigarette/Alcohol use during pregnancy: No Yes

Location of Birth: Hospital Birthing Center Home

Birth Intervention: Forceps Vacuum Extraction Caesarean Section: (Emergency or Planned)

Complications during delivery? No Yes If Yes, list: ______________________________

Genetic disorders or disabilities? No Yes If Yes, list: ______________________________

Birth Weight: ___________ Birth Length: ___________ APGAR Scores: ________, ________

FEEDING HISTORY:

Breast Fed: No Yes If Yes, how long: _______________________________________

Formula Fed: No Yes If Yes, how long: ______________ Type: __________________

Introduced Solids @: ___________ Months Cows' Milk @: _____________ Months

Food / Juice Allergies or Intolerances: No Yes

If Yes, list:____

DEVELOPMENTAL HISTORY:

During these 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 (spine & nerve interference).

At what age was your child able to:

Respond to Sound _________ Cross Crawl __________ Respond to Visual Stimuli __________

Stand Alone _________ Hold Head Up __________ Walk Alone_________ Sit Up ___________

Has your child fallen head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.)? No Yes

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, Wrestling, etc.)? No Yes

If Yes, List: ____

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

If Yes, explain: ____

Has your child been seen at the emergency room? No Yes

If Yes, explain: ____

Other traumas not described above? No Yes

If Yes, explain: ____

Prior surgery? No Yes

If Yes, list: ____

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: _______________

Parent/Guardian Signature:_______________________________________ Date:___________