

PEDIATRIC HISTORY FORM

Stuckey Chiropractic

Today's Date ____/____/____

Name _____ Date of Birth ____/____/____ Social Security # ____-____-____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ Mothers mobile: _____ Fathers mobile: _____

Mother _____ DOB ____/____/____ Father _____ DOB ____/____/____

Pediatrician/Family MD _____ City & State _____ Last Visit: ____/____/____

Purpose of last visit _____

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____ Age: _____

Ever been under chiropractic care? No Yes: Who/When? _____

Who is responsible for this bill? Mother Father Other (please explain) _____

Insurance Company _____

PREGNANCY HISTORY:

Third Trimester Presentation: _____ Vertex _____ Breech _____ Transverse _____ Face/Brow

Type of Birth: _____ Normal Vaginal _____ Forceps _____ Cesarean _____ Suction Cap or Vacuum

Location: _____ Home _____ Hospital _____ Birthing Center _____ Other: _____

Problems during Pregnancy: _____

Problems during Labor/Delivery: _____

Was there presence of: _____ Jaundice? (Yellow) _____ Cyanosis? (Blue) _____ Congenital Anomalies/Defects?

If yes, please explain _____

INFANT HISTORY:

Infant feeding: _____ Breast _____ Bottle If Bottle; which Formula? _____

Number of Hours sleep per night _____ Quality of Sleep: _____ Good _____ Fair _____ Poor

List all **IMMUNIZATIONS** you child has had: _____

Has your child ever been treated at the emergency room? _____ If yes; please explain _____

Has your child ever been hospitalized? _____ If yes; please explain _____

Has your child ever had any Surgeries? _____ If yes; please explain _____

Is your child currently on any medication? _____ If yes; please list: _____

AT WHAT AGE DID THE CHILD:

Respond to sound _____ Follow an object with his/her eyes _____ Hold heel up _____
Sit Alone _____ Crawl _____ Stand _____ Walk alone _____

AT WHAT AGE, IF EVER, DID CHILD SUFFER FROM THE FOLLOWING:

Chicken pox _____ Mumps _____ Measles _____ Rubella _____
Whooping Cough _____ Other: _____

HAS YOUR CHILD EVER SUFFERED FROM:

- Headaches
- Dizziness
- Fainting
- Seizures/Convulsions
- Heart Trouble
- Chronic Earaches
- Sinus Trouble
- Asthma
- Colds/Flu
- Colic
- Orthopedic Problems
- Neck Problems
- Arm Problems
- Leg Problems
- Joint Problems
- Backaches
- Poor Posture
- Scoliosis
- Walking Trouble
- Broken Bones
- Digestive Disorders
- Poor Appetite
- Stomach Aches
- Reflux
- Constipation
- Diarrhea
- Hypertension
- Anemia
- Bed Wetting
- Sleeping Problems
- Behavioral Problems
- ADD/ADHD
- Ruptures/Hernia
- Muscle Pain
- Growing Pains
- Allergies to _____
- Allergies to _____
- Allergies to _____
- Other: _____
- Other: _____

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS:

- Fall in baby walker
- Fall from crib
- Fall from high chair
- Fall from changing table
- Fall from bed or couch
- Fall off swing
- Fall off slide
- Fall off monkey bars
- Fall off skateboard or skates
- Fall off bicycle
- Fall down stairs
- Other: _____

Has your child ever sustained an injury playing organized sports? _____ If yes; please explain _____

Has your child ever sustained an injury in an auto accident? _____ if yes; please explain _____

FAMILY HISTORY:

Please indicate if your child or a family member has had any of the following: Write "C" for child, "F" for family member:

- _____ Heart Disease
- _____ Cancer
- _____ Gastrointestinal disease
- _____ Diabetes
- _____ High / Low blood pressure
- _____ Memory/mood disorder
- _____ Stroke
- _____ Asthma
- _____ Thyroid problem

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____ Wellness _____ Check-up _____ Other: _____

_____ Pain/Discomfort; explain _____

_____ Injury; explain _____

If due to Pain/Discomfort/Injury, please fill out:

1. **Onset** of Problem: Date ____/____/____ _____ Unknown _____ Gradual _____ Sudden
2. **Ever had** this problem **before**? No Yes If yes when? _____
3. Any **bowel or bladder** problems since this problem began?: No Yes (Describe): _____
4. Any **medication taken** for this problem? No Yes: _____
5. Have you seen any **other doctors** for this problem? No Yes: _____
6. How is this problem **NOW**: Rapidly Improving Improving Slowly About the Same Gradually Worsening On & Off

Whom may we thank for referring you to our office today? _____

I understand that I am directly and fully responsible to Stuckey Chiropractic for all chiropractic care my child receives. I hereby authorize Dr. Mark Stuckey, D.C. and whomever he may designate as his assistants to treat my minor child by any means, methods, and/or techniques the doctor deems necessary to treat my child's condition at any time throughout the entire clinical course of their care.

Parent's or Legal Guardian's Signature

Date