# *A Center for Well-Being*
# *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 human health for your family.***

Patient Name:_____SS#:_____Birth Date:_____
Address:_____City:_____State:_____ Zip:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Sex:_____ Weight:_____ Height:_____
Names of Parents/Guardians:_____ Referred By:_____

**Purpose for Contacting Us?**_____
Other Doctors Seen for this Condition: N / Y Doctors' Names and Prior Treatments:_____
_____
Other Health Problems?_____

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

| | | | | |
|---|---|---|---|---|
| ___Ear Infections | ___Digestive Problems | ___Car Accident | ___Headaches | ___Growing/Back Pains |
| ___Asthma/Allergies | ___Bed Wetting | ___Chronic Colds | ___Scoliosis | ___Temper Tantrums |
| ___Colic | ___Seizures | ___Recurring Fevers | ___ADHD | ___Other |

Please specify 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 has received there? _____

Number of series 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:_____ List:_____
Additional medications taken during his/her lifetime:_____

Vaccination History:_____

**Prenatal History:**

Name of Obstetrician/Midwife:_____

Complications during pregnancy? N / Y List:_____

Medications during pregnancy/delivery? N / Y List:_____

Ultra sounds during pregnancy? N / Y Number:_____ Cigarette/Alcohol use during pregnancy? N / Y

Location of birth: ____Hospital ____Birthing Center ____Home

Birth Intervention: ____Forceps ____Vacuum Extraction ____Emergency Caesarian Section ____Planned Caesarian Section

Complications during delivery? N / Y List:_____

Genetic Disorders or Disabilities? N / Y List:_____

Birth Weight:_____ Birth Length:_____ APGAR Scores:_____

**Feeding History:**

Breast-fed? N / Y How Long?_____

Formula fed? N / Y How Long?_____ Type:_____

Introduced: Solids at _____ months; Cow's milk at _____ months.

Food/Juice allergies or intolerances? N / Y 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 | _____Cross crawl |
| _____Respond to visual stimuli | _____Stand alone |
| _____Hold head up | _____Walk alone |
| _____Sit up | |

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc). Was this the case with your child? N / Y

Is/has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc)? N / Y List:_____

Has your child ever been involved in a car accident? N / Y List:_____

Has your child ever been seen on an emergency basis? N / Y List:_____

Other traumas not described above:_____

Prior surgery? N / Y List:_____

Menarche? N / Y Age: of onset:_____

**Childhood Diseases:**

| | | |
|---|---|---|
| Chicken Pox: N / Y Age:_____ | Rubeola: N / Y Age:_____ | Whooping Cough: N / Y Age:_____ |
| Rubella: N / Y Age:_____ | Mumps: N / Y Age:_____ | Other:_____ 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 Doctor 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:_____