PEDIATRIC HISTORY FORM

Child's Name ______________________________________ Parent(s)/Guardian(s) Name _______________________________________

Address ____ City _________________________ State ______ Zip __________________

Home Phone _______________________ Work Phone __________________________________ Cell ____________________________

Is it ok to contact you at work? Yes / No E-mail ____

Child's Social Security # _______________________________ Sex _______ Birthdate ____________________________ Age ________

What brings your child to our office? ___________________________ When did the this first begin? ____________________________

Has your child ever had a similar condition? Yes / No Please explain: ____

Has your child been treated for this problem before? Yes / No Please explain: ____

Who is your family's primary care physician? _____________________________ Where do they practice? _______________________

Have you or your child ever had chiropractic care before? Yes / No

If yes, who was the chiropractor? ______________________________ Were you pleased with your care? Yes / No

Please list any drugs or medications your child is taking ____

Please list any vitamins/herbs/homeopathic/other your child is taking ____

Please list any allergies your child has ____

Child's birth was at: Home / Birthing center / Hospital The OB / Midwife / Doula was ___________________________________

Child's birth was: Natural vaginal (no medications/interventions)

Vaginal with interventions: Induction / Pain Medication / Epidural / Vacuum extraction / Forceps

C- Section: Scheduled / Emergency

Childs birth weight _______________ Childs birth height ___________ Current Weight:____________ Current Height:____________

At what age did the child:

Respond to sound _______ Follow an object ________ Hold head up __________ Vocalize __________

Sit alone ____________ Teethe ______________ Crawl ____________ Walk ____________

Is/was your child breastfed? Yes / No If yes, how long? ______________________________ Any problems with latching? Yes / No

Formula introduced at age ___________ What type? ___________________________________

Introduction of cow's milk at age ___________ Began solid foods at age ________________

Please list any food/juice intolerances ____

Did mother smoke during pregnancy? Yes / No Did mother drink alcohol during pregnancy? Yes / No

Any illness of mother during pregnancy? Yes / No If yes, please explain ____

List any drugs/medications (including over the counter) taken during pregnancy ____

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List any supplements taken during pregnancy ____

Has child received any vaccinations? Yes / No If yes which ones and list any reactions _____________________________________

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Are there any vaccines you have chosen to avoid? Yes / No If yes, for what reason? ____

Has child received any antibiotics? Yes / No If yes, how many times and list reason ____

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Please circle any of the following conditions your child has ever suffered from:

Asthma	Ear Aches/Infections	Colic	Scoliosis	Digestive Problems	ADD/ADHD
Bed Wetting	Broken Bones	Seizures	Chronic Colds	Recurring Fevers	Headaches
Car Accident	Behavioral Problems	Growing Pains	Constipation	Backaches	Dizziness

Any night terrors, sleepwalking or difficulty sleeping? Yes / No If yes, please explain _______________________________________

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Has your child ever been hospitalized/had surgery? Yes / No If yes, please explain _______________________________________

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Did your child fall from a high place (bed, changing table, down stairs, etc) during their first year of life? Yes / No

Is/Has your child been involved in any high impact or contact type sports? (Soccer, Football, Hockey, Wrestling, etc) Yes / No

Please List: ____

Age child began daycare _________________ Average number of hours of screen time (TV, iPad, etc) per week ____________

How would you describe your child's diet? ____

Are there any other health concerns or anything else you'd like us to know about your child? _______________________________

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What would you like to gain from chiropractic care? ____