PEDIATRIC HISTORY FORM

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: _____ Age: _____ M☐ F☐ Birth Date: _____/_____/_____
Address: _____ Email Address: _____
Phone: _____
Health Card: _____
Names of Parents/Guardians: _____

Purpose for contacting us? _____

_____

Have you seen any other doctors for this: ☐N ☐Y
If yes, doctors' names and prior treatments: _____

_____

Other Health problems? _____

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 ☐ADHD ☐Recurring fevers ☐Growing pains ☐Back pain
☐Digestive problems ☐Colic ☐Bed wetting ☐Car accident ☐Temper tantrums
☐Sleeping problems ☐Mood swings ☐Depression ☐Dizziness ☐Constipation

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? ☐N ☐Y
Number of doses of Antibiotics your child has taken:
During the last six months:_____ Total during his/her lifetime: _____
Number of doses of other prescription medications your child has taken:
During the last six months:_____ Total during his/her lifetime: _____
List: _____
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 _____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 _____ _____

OVER

Feeding History:

Breast Fed: ☐ N ☐ Y How long: _____
Formula Fed: ☐ N ☐ Y How long: _____ Type: _____
Introduce to Solids at _____ Months Cows' milk at _____Months
Food/Juice allergies or intolerances: ☐ N ☐ Y List: _____
_____

Developmental History:

During the following times your child's spine/nervous system 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
_____Respond to visual stimuli
_____Hold Head up
_____Sit up
_____Cross Crawl
_____Stand alone
_____Walk alone

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

Has your child been involved in any high impact or contact type sports (i.e. hockey, soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ☐ N ☐ Y List: _____
_____
Has your child ever been in a car accident? ☐ N ☐ Y List:_____
Has your child been seen on an Emergency basis? ☐ N ☐ Y List: _____
Other traumas not described above? ☐ N ☐ Y List: _____
Any surgeries? ☐ N ☐ Y List: _____
Menarche? ☐ N ☐ Y Age: _____

Childhood Diseases:

Chicken Pox ☐N ☐Y Age _____
Rubella ☐N ☐Y Age _____
Rubeola ☐N ☐Y Age _____
Mumps ☐N ☐Y Age _____
Whooping cough ☐N ☐Y Age _____
Other: ☐N ☐Y 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 A MINOR

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.

Signature: _____ Date: ___/___/___

I give consent to receive emails from Holroyd Family Chiropractic about future appointments, reminders and events.

☐Yes
☐No

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