PEDIATRIC HISTORY FORM

Patient Name: _____ S.S.#_____

Address: _____City: _____

State: _____ Zip Code: _____ Home Phone: _____

Birth Date: _____ /_____ /_____ Sex: _____ Weight: _____ Height: _____'_____"

Referred By: _____ Parent/Guardian: _____

Parents' Work Phone #: _____ Alternate Phone #: _____

REASON FOR VISIT_____

_____

Other Doctors seen for this condition: _____

Other Health Problems? _____

Check any of the following conditions your child has had in the last six months

❑ Ear Infection	❑ Scoliosis	❑ Seizures	❑ Chronic Colds	❑ Headaches
❑ Asthma/Allergies	❑ Digestive Problems	❑ ADHD	❑ Recurring Fever	❑ Growing/Back Pain
❑ Colic	❑ Bed Wetting	❑ Car Accident	❑ Temper Tantrums	❑ Other_____

Family History: _____

Previous Chiropractor: _____

Date of last visit: ____/____/____Reason: _____

Name of Pediatrician: _____

Date of last visit ____/____/____Reason: _____

Number of Doses (Times) Child has Taken Anitbiotics:
During the past six months: _____, Total During His/Her Lifetime: _____

List other Prescription Medications your child has taken: During the past six months: _____

Total During His/Her Lifetime: _____ List Medication Names: _____

_____

Vaccination History: _____

_____

Prenatal History:

Complications During Pregnancy? _____ Y_____ N List: _____

Ultrasounds During Pregnancy? _____ Y_____ N Approximate Number of Times: _____

Medications/Supplements During Pregnancy/Delivery? ____ Y____N
List: _____

Cigarette/Alcohol Use During Pregnancy: _____Y_____N

Location of Birth: (Circle One) Hospital / Birthing Center / Home Birth Intervention: Forceps: ___Y ___ N

Vacuum Extraction: ____ Y ____ N Caesarean Section: _____Y ____ N Circle One: Emergency or Planned?

Complications During Delivery? _____N_____Y, List_____

Genetic Disorders or Disabilities: _____N _____Y, List_____

Circle One: Breast / Formula Fed

Has Your Child Ever Been in a Car Accident? ____ Y____ N, List: _____

Has Your Child Ever Been Seen on an Emergency Basis? ____ Y___ N, List: _____

Other Traumas Not Described Above? ____ Y ___ N, List: _____

Prior Surgery: ____Y ____N List: _____

Childhood Diseases:

Chicken Pox	N/Y, Age____	Mumps	N/Y, Age____
German Measles	N/Y, Age____	Whooping Cough	N/Y, Age____
Measles	N/Y, Age____	Other	N/Y, Age____

AUTHORIZATION FOR CARE OF MINOR:

I hereby authorize this office and its Doctors to administer care to my Son/Daughter as they deem necessary, I clearly under agree that I am personally responsible for payment of all fees by this office.

Parent's Name: _____ Signature:_____

FOR OFFICE USE ONLY: Child's Name: _____

Today's Date: _____

Areas of Concern: _____
_____
_____
_____
_____
_____

Dx: _____