www.align.family
CHIROPRACTIC

Pediatric History Form

Date_____ Referred By_____
Patient Name_____Phone Number_____
Address_____
City_____State_____Zip_____
Birth Date_____Sex_____Weight_____Height_____SS#_____
Names of Parents/Guardians_____
Purpose for contacting us?_____
Other doctors seen for this condition_____
Has your child seen a chiropractor before (where/when)?_____
Check any of the following that your child is experiencing, or has experienced in the past:

☐ Ear Infections	☐ Digestive Problems	☐ ADHD	☐ Temper Tantrums
☐ Asthma	☐ Bed Wetting	☐ Auto Accident	☐ Headaches
☐ Allergies	☐ Seizures	☐ A Fall	☐ Chronic Colds
☐ Colic	☐ Recurring Fevers	☐ Traumatic Birth	☐ Adverse vaccination
☐ Scoliosis	☐ Constipation	☐ Diarrhea	reaction

☐ Other_____
Family History_____
_____
Name of Pediatrician_____Date of last visit_____
Reason_____Treatment_____
Number of doses of antibiotics your child has taken:

1) In last 6 months:_____
2) Total during his/her life:_____

Number of doses of other prescription medications your child has taken:

1) During last 6 months:_____
2) Total during his/her life:_____

Vaccination history:_____
Feeding History:
☐ Breast-fed If yes, how long_____ ☐ Formula, if yes, how long_____
Introduced solids at _____ months. Cow's milk at _____ months.
Prenatal History:
☐ Complications during pregnancy? Explain_____
☐ Ultrasounds during pregnancy? How many?_____
☐ Medications during pregnancy/delivery? List them_____
☐ Cigarette/alcohol use during pregnancy? Frequency_____
Location of Birth ☐ Hospital ☐ Home ☐ Other_____
Birth intervention ☐ Forceps ☐ Vacuum Extraction ☐ C-section
Delivery complications? ☐ No ☐ Yes_____

Birth Weight_____Birth Length_____APGAR Scores_____

Childhood Diseases:

☐ Chicken Pox Age:_____ ☐ Rubeola Age:_____ ☐ Whooping Cough Age:_____

☐ Rubella Age:_____ ☐ Mumps Age:_____ ☐ Other_____

Developmental History:

At what age was your child able to:

Respond to sound	_____	Crawl	_____
Respond to visual stimuli	_____	Stand Alone	_____
Hold head up	_____	Walk Alone	_____
Sit	_____		

Has your child ever been involved in a car accident? ☐ No ☐ Yes (List)_____

Has your child ever fallen? ☐ No ☐ Yes (List)_____

Prior surgery? ☐ No ☐ Yes (List)_____

I hereby authorize Align Family Chiropractic PC to administer care to my son/daughter. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed_____Date_____

Relationship to Patient_____

Email Address _____

Other Emergency Contact:_____Relationship to Child:_____

Contact (phone):_____Permission to bring Child to adjustment (initial):_____

Other Emergency Contact:_____Relationship to Child:_____

Contact (phone):_____Permission to bring Child to adjustment (initial):_____