



210 Western Ave.
South Portland, ME 04106
207-775-7468
www.ifc4me.com

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: _____

Has your child reached the appropriate milestones? Yes/No If no, explain _____

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 _____

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 _____

List any supplements taken during pregnancy _____

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

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 _____

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 _____

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

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

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

How would you describe your child's diet? _____

Any food intolerances/allergies? Yes / No If yes, please explain _____

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

What would you like to gain from chiropractic care? _____