PEDIATRIC HISTORY FORM

Dear new patient,
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: _____AHC# _____
ADDRESS: _____CITY: _____
PROVINCE: _____POSTAL CODE: _____HOME# _____
BIRTHDATE: (M)_____/(D)_____/(Y)_____WORK#_____
SEX: _____WEIGHT: _____HEIGHT: _____
NAMES OF PARENTS/GUARDIANS: _____

PURPOSE FOR CONTACTING US? SPINAL CHECK-UP: _____OTHER:_____

OTHER DOCTORS SEEN FOR THIS CONDITION: _____Y_____N
DOCTORS' NAME & PRIOR TREATMENTS: _____
_____
OTHER HEALTH PROBLEMS: _____
PERTINENT FAMILY HISTORY: _____
HAS THIS CHILD BEEN UNDER PREVIOUS CHIROPRTACTIC CARE: _____Y_____N
DATE OF LAST VISIT: (M)_____/(D)_____/(Y)_____
NAME OF PEDIATRICIAN: _____
DATE OF LAST VIST: (M)_____/(D)_____/(Y)_____REASON: _____
ARE YOU SATISFIED WITH THE CARE YOUR CHILD HAS RECEIVED HERE? _____Y_____N
NUMBER OF DOSES OF ANTIBIOTICS YOUR CHILD HAS TAKEN: _____
DURING THE PAST 6 MONTHS: _____TOTAL DURING HIS/HER LIFETIME: _____
NUMER OF DOSES OF OTHER PRESCRIPTION MEDICATIONS YOUR CHILD HAS TAKEN: _____
DURING THE PAST 6 MONTHS: _____TOTAL DURING HIS/HER LIFETIME: _____
HAVE YOU CHOSEN TO VACCINATE THIS CHILD? _____Y_____N
REACTIONS FOLLOWING VACCINATION (UP TO 30 DAYS POST VACCINE): _____

PRENATAL HISTORY:

NAME OF OBSTETRICIAN/MIDWIFE:_____
COMPLICATIONS DURING PREGNANCY: _____Y_____N, LIST: _____
ULTRASOUNDS DURING PREGNANCY: _____Y_____N, NUMBER: _____
COMPLICATIONS DURING DELIVERY: _____Y_____N, LIST: _____
MEDICATIONS DURING PREGNANCY/DELIVERY: _____Y_____N, LIST: _____
LOCATION OF BIRTH: _____HOSPITAL: _____BIRTH CENTRE: _____HOME: _____
BIRTH INTERVENTION: _____FORCEPS _____VACUUM EXTRACTION
_____CESAREAN SECTION, EMERGENCY OR PLANNED: _____

APGAR SCORES_____, _____CIGARETTE/ALCOHOL USE DURING PREGNANCY: _____Y_____N
GENETIC DISORDERS OR DISABILITIES: _____Y_____N, LIST: _____
BIRTH WEIGHT: _____BIRTH LENGTH: _____

FEEDING HISTORY:

BREAST FED: _____Y_____N, HOW LONG: _____
FORMULA FED: _____Y_____, HOW LONG: _____TYPE: _____
INTRODUCED: SOLIDS AT _____MONTHS, COW'S MILK AT _____MONTHS
FOOD/JUICE ALLERGIES OR INTOLERANCES: _____Y_____N, LIST: _____
_____

DEVELOPMENTAL HISTORY:

ACCORDING TO THE NATIONAL SAFETY COUNCIL, APPROXIMATELY 50% OF CHILDREN FALL FROM A HIGH PLACE DURING THE FIRST YEAR OF LIFE (ie: A BED, CHANGING TABLE, DOWNSTAIRS, ETC). WAS THIS THE CASE WITH YOUR CHILD: _____Y_____N
IS/HAS YOUR CHILD BEEN INVOLVED IN ANY HIGHT IMPACT OR CONTACT TYPE SPORTS (ie: SOCCER, FOOTBALL, GYMNASTICS, BASEBALL, CHEERLEADING, MARTIAL ARTS, ETC): _____Y_____N, LIST: _____
HAS YOUR CHILD EVER BEEN INVOLVED 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: _____
HOSPITALIZATION OR PRIORITY SURGERY: _____Y_____N, LIST: _____

CHILDHOOD DISEASES:

CHICKEN POX	**Y / N**	**AGE_____**	**MUMPS**	**Y / N**	**AGE____**
RUBELLA	**Y / N**	**AGE_____**	**WHOOPING COUGH**	**Y / N**	**AGE____**
RUBEOLA	**Y / N**	**AGE_____**	**OTHER**	**Y / N**	**AGE____**

DOES YOUR CHILD OR HIS/HER SIBLINGS SUFFER FROM:

ASTHMA	**Y / N**	**AGE_____**	**SKIN PROBLEMS**	**Y / N**	**AGE____**
ALLERGIES	**Y / N**	**AGE_____**	**DIFFICULTY SLEEPING**	**Y / N**	**AGE____**
HYPERACTIVITY	**Y / N**	**AGE_____**	**COLIC**	**Y / N**	**AGE____**
BED WETTING	**Y / N**	**AGE_____**	**DIGESTIVE DIFFICULTIES**	**Y / N**	**AGE____**
EAR INFECTIONS	**Y / N**	**AGE_____**	**(CONSTIPATION, DIARRHEA)**	**Y / N**	**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 UNDERSTAND AND AGREE THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL FEES CHARGED BY THIS OFFICE.

I HAVE READ THE ABOVE STATEMENT AND CONSENT TO TREATMENT.

Signature_____ Date Signed _____