

# 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 \_\_\_\_\_ S.S.# \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Guardian's Work Phone \_\_\_\_\_

Sex \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Referred By \_\_\_\_\_

Names of Parents/Guardians \_\_\_\_\_ Number of Siblings \_\_\_\_\_

**Purpose for Contacting Us** \_\_\_\_\_

Other doctors seen for this condition (Names, dates, and types of treatments) \_\_\_\_\_

Other health problems \_\_\_\_\_

Check any of the following conditions that your child has suffered and write in the age at which it happened:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Ear Infections _____   | <input type="checkbox"/> Digestive Problems _____ | <input type="checkbox"/> Car Accident _____    | <input type="checkbox"/> Headaches _____          |
| <input type="checkbox"/> Asthma/Allergies _____ | <input type="checkbox"/> Bed Wetting _____        | <input type="checkbox"/> Chronic Colds _____   | <input type="checkbox"/> Growing/Back Pains _____ |
| <input type="checkbox"/> Colic _____            | <input type="checkbox"/> Seizures _____           | <input type="checkbox"/> Recurring Fever _____ | <input type="checkbox"/> Other _____              |
| <input type="checkbox"/> Scoliosis _____        | <input type="checkbox"/> ADHD _____               | <input type="checkbox"/> Temper Tantrums _____ |   |

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? \_\_\_\_ Explain \_\_\_\_\_

Number of doses of antibiotics your child has taken: In past 6 months \_\_\_\_ During his/her lifetime \_\_\_\_

List of Antibiotics taken \_\_\_\_\_

Vaccination History \_\_\_\_\_

## **Prenatal History**

Name of Obstetrician/Midwife \_\_\_\_\_

Complications During Pregnancy?  Yes  No If yes, list \_\_\_\_\_

## **During Pregnancy:**

Ultrasounds?  Yes  No If yes, how many? \_\_\_\_\_ Medications \_\_\_\_\_

Cigarette/Alcohol Use  Yes  No Falls/Injuries  Yes  No Physical/Mental Abuse  Yes  No

Location of Birth  Home  Birthing Center  Hospital Name \_\_\_\_\_  
Birth Intervention  Forceps  Vacuum Extractor  C-Section  Emergency  Planned  
Breach/Cephalic \_\_\_\_\_ Labor Induced  Yes  No Length of Delivery \_\_\_\_\_  
Complications During Delivery  Yes  No If yes, list \_\_\_\_\_  
Genetic Disorders/Disabilities \_\_\_\_\_ Birth Weight \_\_\_\_\_ Length \_\_\_\_\_ APGAR Score \_\_\_\_\_

### **Feeding History**

Breast Fed  Yes  No How Long \_\_\_\_\_ Formula Fed  Yes  No How Long \_\_\_\_\_ Type \_\_\_\_\_  
Age Introduced to Solids \_\_\_\_\_ Age Introduced to Cow's Milk \_\_\_\_\_ Food/Juice Allergies \_\_\_\_\_

### **Developmental History**

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertical subluxation (spinal nerve interference). At what ages was your child able to:

Respond to Sound \_\_\_\_\_ Walk Alone \_\_\_\_\_ Sit Up \_\_\_\_\_  
Hold Head Up \_\_\_\_\_ Respond to Visual Stimuli \_\_\_\_\_  
Cross Crawl \_\_\_\_\_ Stand Alone \_\_\_\_\_

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, a changing table, down stairs, etc). Was this the case with your child?  Yes  No Explain \_\_\_\_\_

Has your child been involved in any high impact or contact sports (i.e. Soccer, Football, Gymnastics, Cheerleading, Baseball, Martial Arts, etc.)  Yes  No List \_\_\_\_\_

Has your child been involved in a car accident (even a fender bender)?  Yes  No If yes, was your child strapped?  Yes  No

Has your child ever been taken to the emergency room?  Yes  No Explain \_\_\_\_\_

Other traumas not described above \_\_\_\_\_

Prior Surgery \_\_\_\_\_ Menarche  Yes  No Age \_\_\_\_\_

### **Childhood Diseases**

*Check the box if your child has had one of the listed and fill in the age when they had it.*

Chicken Pox \_\_\_\_\_  Mumps \_\_\_\_\_  Rubella \_\_\_\_\_  
 Whooping Cough \_\_\_\_\_  Rubeola \_\_\_\_\_  Other \_\_\_\_\_

**WE ARE HERE TO SERVE YOU AND WE ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.**

I hereby authorize this office and it's 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. Any risks regarding chiropractic care will be explained to me upon my request. The following signature also authorizes the release of medical information and assignment of benefits to: American Radiological Services for the interpretation of my child's x-rays.

Signed \_\_\_\_\_ Witnessed \_\_\_\_\_ Date \_\_\_\_\_