PEDIATRIC HISTORY FORM

Dear Parent,

It is our 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 serve you better, please complete the following information. We look forward to working with you and your family to build better health.

Patient Name: _____S.S. _____

Address: _____ _____City:_____

State: _____ Zip: _____ Home Phone: _____

Birth Date: _____/_____/____ Age_____Work Phone: _____Cell _____

Sex: M F Weight: _____ Height: _____ Referred by: _____

Names of Parents / Guardians: _____

Purpose for Contacting Us? _____
Other Doctors Seen for this Condition Y N Doctors' Names and Prior Treatment:
Other Health Problems?

Check any of the following Conditions your child has suffered from during the past six months:
() Ear Infections () Scoliosis () Seizures () Chronic Colds ()Headaches
() Asthma/Allergies () Digestive Problems () Recurring Fevers () ADHD
() Growing/back pain () Colic () Bed Wetting () Temper Tantrums () Car Accident

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? N Y Why:? _____

Has your child been vaccinated: Y N Age of first vaccination: _____

Number of doses of Antibiotics your child has taken:
During the past six months: _____ Total during his/her lifetime: _____ List: _____

Number of Prescription medications your child has taken:
During the past six months: _____ Total during his/her lifetime: _____ List: _____

Prenatal History:
Name of Obstetrician / Midwife: _____
Complications During Pregnancy? N Y List:_____
Ultrasounds During: N Y, Number: _____
Medications During Pregnancy/Delivery: N Y List: _____
Cigarette/Alcohol use during pregnancy: N Y
Location of Birth: Hospital _____ Birthing Center _____ Home _____

Birth Intervention:
Forceps _____ Vacuum Extraction _____ Caesarian Section _____ Emergency or Planned

Complication During Delivery? N Y, List _____

Genetic Disorders or Disabilities: Y N, List _____

Birth Weight _____ Birth Length: _____ APGAR Score: _____

Feeding History:

Breast Fed: N Y , How long? _____

Formula Fed: N Y , How long? _____ Type? _____

Introduced to solids at: _____ Months Cows milk at _____ Months

Food/Juice Allergies or Intolerances: N Y, List: _____

According to the National Safety Council, approximately 50% of all children fall head first from a high place during the first year of their life (i.e. a bed, changing table, stairs, etc.) Was that true of your child? N Y Explain: _____

Is/Has your child ever been involved in any high impact or contact type sports (i.e. soccer, football gymnastics, baseball, cheerleading, martial arts) ? Y N, List:
_____

Has your child ever been involved in a car accident? N Y List: _____

Has your child ever been seen on an emergency basis? N Y List: _____

Other Traumas not described above: N Y List? _____

Prior Surgery: N Y List: _____

We are here to serve you and encourage you to ask questions. Your participation is vital and will help determine your results.

Authorization for care of Minor

I hereby agree this office and its Doctors to administer are to my son/daughter, as they may deem necessary. I clearly understand and agree that I am personally responsible for payment for all fees charged by this office

Name of Insurance Company: _____ Policy# _____

Insured's Name _____Insured's Date of Birth _____

Insured's Social Security #: _____

Signed: _____ Witnessed: _____ Date: _____