PEDIATRIC HISTORY FORM

Dear New Patient,

It is a pleasure to welcome you to our family of healthy and happy 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:_____ SS#:_____

Address:_____ City:_____

State:_____ Zip:_____ Home Phone:_____

Birth Date:_____ Sex: M F Weight:_____ Height:_____

Name of Parent/Guardian:_____ Referred By:_____

Purpose For Contacting Us?_____

Other Doctors Seen for this Condition: No Yes Doctor's Name and Prior Treatments:_____

_____

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 ___ ADHD ___ Recurring Fevers ___ Digestive Problems ___ Colic
___ Growing/Back Pains ___ Bed Wetting ___ Car Accident ___ Temper Tantrums
___ Other:_____

Family History:_____

Previous Chiropractor:_____ Date of Last Visit:_____

Reason for Previous Care:_____

Name of Pediatrician:_____ Date of Last Visit:_____

Reason for that visit:_____

Were You Satisfied with the care your Child has received there? Yes No

Number of Doses of Antibiotics your child has taken:
During the past six months:_____, During his/her lifetime:_____

Vaccination History:_____

Prenatal History:

Name of Obstetrician/Midwife:_____

Complications During Pregnancy? No Yes Describe:_____

Ultrasounds During Pregnancy? No Yes Number:_____

Medication During Pregnancy? No Yes List:_____

Cigarette/Alcohol Use During Pregnancy? No Yes

Location of Birth: ___ Hospital ___ Birthing Center ___ Home

Birth Intervention: ___ Forceps ___ Vacuum Extraction ___ Ceasarian Section. Emergency or Planned

Complications During Delivery? No Yes Describe:_____

Genetic Disorders or Disabilities? No Yes Describe:_____

Birth Weight: _____ Birth Length: _____ APGAR Score: _____

Feeding History:

Breast Fed: No Yes How Long?_____

Formula Fed: No Yes How Long?_____ Type:_____

Introduced to solids at: _____ Months Cows' Milk at _____ Months

Food/Juice Allergies or Intolerances: No Yes Describe:_____

_____

Developmental History:

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

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

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

Is/has your child been involved in any high impact or contact type sports? (ie. Soccer, Football, Gymnastic, Baseball, Cheerleading or Martial Arts): No / Yes List:_____

Has your child ever been involved in a car accident? No / Yes List:_____
Has your child been seen on a emergency basis? No / Yes List:_____
Other traumas not described above? No / Yes List:_____
Prior Surgeries? No / Yes List:_____
Menarche (onset of menstruation): No / Yes Age:_____

Childhood Diseases:

Chicken Pox: No / Yes Age:____ Mumps: No / Yes Age:____ Rubella: No / Yes Age:____
Whooping Cough: No / Yes Age:____ Rubeola: No / Yes Age:____ Other:_____

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 authorize this office and its Doctor 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.

Name of Insurance Company:_____ Date:_____

Signed:_____ Witnessed:_____

(4/02)