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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: ____
Address: ____City:_________________________
State: __________________ Zip: _____________ Home Phone:_____________________________
Birth Date: ___/___/____Work Phone: __________________ Cell Phone: _______________________
Sex: _________ Weight: ___________ Height: ______ Referred By: _____________________________
Names of Parents/Guardians: ____
Purpose for contacting us? ____

Other doctors seen for this condition? ___N___Y
Doctors' 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___	Asthma/Allergies___
Headaches___	Digestive Problems___	ADHD___	Growing/ Back Pains___	Bed Wetting___
Recurring Fevers___	Temper Tantrums___	Colic___	Other_____________________________	

Family History: ____
Previous Chiropractor: ____
Date of last visit: _____/_____/_____ Reason:____
Are you satisfied with the care your child received there? ___N ___Y
Number of doses of Antibiotics your child has taken: Past 6 months:______, Total during lifetime: _________
Number of Doses of Other Prescription Medications your child has taken:
During the past six months:__________, Total during his / her lifetime: _________
List: ____

Vaccination History: ____

Prenatal History:
Name of Obstetrician / Midwife: ____
Complications during pregnancy? _____N_____Y, List_________________________________
Ultrasounds during pregnancy? _____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; ____ C-Section: ___ Emergency; ___ Planned.
Complications during delivery? ______ N _______Y, List: ___________________________
Genetic disorders or disabilities? ______ N______Y, List: ___________________________

Feeding History:
Breast fed? ____N____Y, How long? _________
Formula fed? ______ N ____Y, How long? ________ Type: ___________________________
Introduced to solids at: ________ Months, Cow's milk at _________Months
Food / Juice allergies or intolerances? ____ N____Y, List: ___________________________

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 vertebral subluxation (spinal nerve interference). At what age was your child able to:

Respond to sound _______ Respond to visual stimuli __________ Cross crawl ________
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 (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child? ______N______Y
Is / Has your child been involved in any high-impact or contact- type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? _____N____Y, List: ___________________________
Has your child ever been involved in an automobile accident? ____N____Y, List date/injuries ______________
____
Has your child been seen on an emergency basis? ____ N_____Y, List dates/reasons _________________
____
Other traumas not described above? _____N____Y, List dates/reasons ______________________
____
Prior surgeries? ____ N____Y, List dates/reasons ________________________________
____
Menarche? ____N____Y, Age began _____________ Complications? ______________________

Childhood Diseases:
Chicken Pox: ___ N ___Y, Age_____ Mumps: ___N ___Y, Age______ Rubella: ___ N ___Y, Age_____
Whooping Cough: ___N ___Y, Age____ Rubeola: ___ N ___Y, Age_____ Other: ___N ___Y, Age______; 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 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.

Name of Insurance Company: _________________________ Policy #:_________________________

Signed______________________________Witnessed:____________________ Date:______________

Print Name: _________________________ ______________________