



PEDIATRIC HISTORY

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.#: _____
Address: _____ City: _____
State: _____ Zip: _____ Home Phone _____
Birth Date: ____/____/____ Work Phone: _____
Sex: ____ Weight: _____ Height: _____ Referred By: _____
Names of Parents/Guardians: _____

Purpose For Contacting Us

Other Doctors Seen for this Condition: ___N___Y,
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 ADHD
 Recurring Fevers Growing/Back Pain Colic Bed Wetting
 Car Accident Temper Tantrums Other _____

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
Number of Doses of Antibiotics Your Child has Taken:
During the Past Six Months: _____, Total During His/Her 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 ___ Caesarian Section, Emergency of Planned?
Complications During Delivery? ___ N ___ Y, List: _____
Genetic Disorders or Disabilities: ___ N ___ Y, List: _____
Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

Feeding History:

Breast Fed: _____ N _____ Y, How long: _____
Formula Fed: _____ N _____ Y, How long: _____ Type: _____
Introduction to Solids at: _____ Months, Cows' Milk at _____ Months
Food/Juice Allergies or Intolerances: _____ N _____ Y, List: _____

Developmental History:

During the following times you child's spine is most vulnerable to stress and should routinely be check by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spine 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 form a high place during their firstyear 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 a Car Accident? _____ N _____ Y, List: _____
Has Your Child Been Seen on an Emergency Basis? _____ N _____ Y, List: _____
Other Traumas Not Described Above? _____ N _____ Y, List: _____
Prior Surgery: _____ N _____ Y, List: _____
Menarche: _____ N _____ Y, Age: _____

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 _____

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

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to me 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: ___ / ___ / ___