Pediatric History Form

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. Many types of stressors (physical, mental, and chemical) can interfere with your child's growing brain, spine and nervous system. 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.

Child's Name: ___________________________S.S.#: ___________________Birth Date: ___/___/___

Male/ Female (Circle one) Weight: _______lbs. Height_____ft.______in.

Phone #_________________ Parent's Cell: ________________ Referred by:____________________________

Address:____City:______________________________

State:________ Zip:_________________ Parent/ Guardian:____

Reason for pursuing care: ☐ maintenance ☐ improved health ☐ problem: ______________________

Other doctors seen for this condition? Y/ N Doctor's names and prior treatment:

____

List any other health problems: ____

Family history: ____

Check any of the following conditions that currently apply:

__ Ear infections	__ Scoliosis	__ Chronic colds	__ Headaches
__ Allergies	__Digestive problems	__ADHD/ADD	__ Recurring Fevers
__ Colic	__Growing/ back pains	__Bed wetting	__Temper tantrums
__ Seizures	__Asthma	__Car accident: When? ________	

Other: ____

Previous Chiropractic Care? Y/ N Last visit: __/__/__

Name of Pediatrician: ____ Last visit: __/__/__

Are you satisfied with the care your child has received at the pediatrician? Y / N

# of Doses of antibiotics your child has taken: Past 6 months______ Total lifetime _______

Present prescription drugs/ dosage? ____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.)

____

__________________________________ __________________________________

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Pediatric History Form Continued

Child's Name ____ Date: __________________________

Prenatal History- (Circle what applies)

Name of Obstetrician/ Midwife: ____

Complications during pregnancy/ delivery? Y / N Explain: _____________________________________

Ultrasounds during pregnancy? Y / N How many?______

Medications taken during pregnancy/ delivery? Y / N List:______________________________________

Cigarette/ Alcohol use during pregnancy? Y / N

Location of birth : ☐ Hospital ☐ Birthing Center ☐ Home

Birth Intervention:☐ Forceps ☐ Vacuum Extraction ☐ Caesarian Section

If Caesarian Section, was it ☐ Emergency ☐Planned

Genetic disorders/ disabilities? Y / N List: ____

Birth Weight: _____________ Birth Length: ___________ APGAR Scores: _____-_____

Feeding History

Breast Fed: Y/N How long? __________ Formula Fed: Y/N How long? _______ Type:________

Introduced to: Solid Foods @_______ months Cow's milk @ ______ months

Food/ Juice allergies or intolerances: Y/ N List: ____

Developmental History

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 stimuli ________Cross Crawl ________ Stand alone _________Sit up

________ Respond to visual stimuli _________ Hold head up __________ Walk 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, changing table, down stairs)

Did your child have a fall similar to what was described above? Y / N
Explain:____

Has your child been involved in any sports? Y / N List: ____

____

Has your child been seen by a physician on an emergency basis? Y/N Explain: ______________________

_________________________________ ____
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Other traumas not described above? ____

Lifestyle- please check what applies

Does your child: ☐ eat 3-4 servings of veggies daily? ☐ drink PURE water daily?

☐ go outside on a daily basis? ☐ watch TV every day? ☐ play video/computer games daily?

Hobbies/ interests: ____

____

Is there anything else you would like us to know about your child? (besides how absolutely amazing they are ☺) ____

Parent/ Guardian name: _____________________________________Signature: ____________________