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. 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 Information:

Patient Name:_____ Birth Date: _____/_____/_____ Sex: M F Weight:_____ Height:_____

Address:_____City, State, Zip:_____

Home Phone:_____ Mom's Cell:_____

Dad's Cell:_____ Parents Names:_____

Referred By:_____

Name of Insurance Co:_____ Policy #:_____ Group #:_____

Name of Insured:_____ Birth Date of Insured: _____/_____/_____

Purpose for today's Visit_____

Other Doctors seen for this? Y N Drs Names and treatments_____

Other Health Problems? _____

Circle any of the following conditions your child has experienced:

Ear Infections □ Scoliosis □ Seizures □ Chronic Colds □ Asthma/Allergies
□ Colic □ ADHD □ Bed Wetting □ Digestive Disorder Growing pains
□ Car Accident □ Temper Tantrums □ Other:_____

Previous Chiropractor:_____ Date of last visit: ____/____/____ Reason:_____

Name of Pediatrician:_____ Date of last visit: ____/____/____ Reason:_____

May we contact your pediatrician if necessary? Y N Are you satisified with the care your child has received there? Y N

Number of doses of Antibiotics your child has taken during past 6 mo: _____ Total During lifetime _____

Vaccination history: _____

Any other prescription medications your child has been on: _____

Prenatal History:

Complications during pregnancy? Y N List:_____

Ultrasounds? Y N Medication 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 C-Section – emergency or planned

Complications during delivery? Y N List:_____

Genetic disorders or 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 solids at: _____months, Cow's milk at _____ months

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

Childhood Disease:

Chicken Pox Y/N Age:____ Mumps Y/N Age:____ Rubella Y/N Age:____

Whooping Cough Y/N Age:____ Rubeola Y/N Age:____ Other Y/N Age:____

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 spinal nerve interference. At what age was your child able to:

_____Respond to sound _____Respond to visual stimuli _____Hold head up

_____Sit up _____Cross crawl _____Stand alone _____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, bed, changing table, down stairs, etc.). Was this the case with your child? Y N

Is/Has your child been involved in any high impact or contact sports? (soccer, football, gymnastics, cheerleading, martial arts, etc)

Y N List:_____

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

Has your child ever been to the emergency room for any trauma? Y N List:_____

Symptoms:

Worst symptom:_____ When did it begin/what happened?_____

Progression (circle): same better worse Pain is (circle): constant comes and goes

Better with (circle all that apply): rest ice heat stretching exercise pain relievers topical creams other:_____

Worse with (circle all that apply): sitting standing walking bending other:_____

Worse during (circle): morning afternoon evening during sleep

Quality of pain (circle all that apply): sharp shooting dull ache burning stabbing stiff throbbing numbness

Severity of pain: 0 1 2 3 4 5 6 7 8 9 10 Does your pain radiate into arms? Y N Legs? Y N

What treatment have you received for this condition (circle): medication physical therapy surgery other:_____

List how this problem affects any area of your life (ex: work, home, kids, activities, etc) 1. _____

2. _____

3. _____

Symptom #2:_____ When did it begin/what happened?_____

Progression (circle): same better worse Pain is (circle): constant comes and goes

Better with (circle all that apply): rest ice heat stretching exercise pain relievers topical creams other:_____

Worse with (circle all that apply): sitting standing walking bending other:_____

Worse during (circle): morning afternoon evening during sleep

Quality of pain (circle all that apply): sharp shooting dull ache burning stabbing stiff throbbing numbness

Severity of pain: 0 1 2 3 4 5 6 7 8 9 10 Does your pain radiate into arms? Y N Legs? Y N

What treatment have you received for this condition (circle): medication physical therapy surgery other:_____

List how this problem affects any area of your life (ex: work, home, kids, activities, etc) 1. _____

2. _____

3. _____

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.

Signed: _____Date:_____

(parent/guardian)