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: _____ S.S.#: _____
Address: _____ City: _____
State: _____ Zip: _____ Home Phone: _____
Birth Date: _____ / _____ / _____ Work Phone: _____
Sex: _____ Referred by: _____
Names of Parents/Guardians: _____

Purpose for Contacting Us? _____
Other doctors seen for this condition? (Y / N) If yes, Dr.'s name and 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 Pains
Colic	Bed Wetting	Car Accident	Temper Tantrums	Other_____

Family Health 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? (Y / N)

Number of doses of <u>antibiotics</u> your child has taken:
During the past six months: _____ During his/her lifetime: _____ List: _____

Vaccination History: _____

Prenatal History:
Name of obstetrician/midwife: _____
Complications during pregnancy? (Y / N) List: _____
Ultrasounds during pregnancy? (Y / N) Number: _____
Medications 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: Emergency? (Y/N)
Complications during delivery? (Y / N) List: _____
Genetic disorders or disabilities: (Y / N) List: _____
Birth Weight: _____ Birth Length: _____

Feeding History:
Breast Fed: (Y / N) How long: _____
Formula Fed: (Y / N) How long: _____ Type: _____
Introduced to Solids at: _____ months, cows' milk at _____ months
Food/Juice Allergies or Intolerances: (Y / N) List: _____

Developmental History:
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). Was this the case with your child? (Y / N)

Is/has your child been involved in any high impact or contact type sports? (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts)? (Y / N) List: _____

Has your child ever been involved in a car accident? (Y / N) List: _____
Has your child been seen on an emergency basis? (Y / N) List: _____
Other traumas not described above? (Y / N) List: _____
Prior Surgery? (Y / N) List: _____

Childhood Diseases

Chicken Pox	Y / N, Age_____	Mumps	Y / N, Age _____
Rubella	Y / N, Age_____	Whooping Cough	Y / N, Age _____
Measles	Y / N, Age_____	Other	Y / N, Age _____

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