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: _____ SSN: _____
Address:_____ City: _____
State: _____Zip:_____ Home Phone:_____
Birth Date: _____ Sex ___ M ___ F Weight: _____ Height:_____
Name of Parents/Guardians: _____ Work Phone: _____
Referred By:_____
Purpose for contacting us? _____
Other Doctors seen for this condition? ____ Y ____ N If Yes, Doctors names and Prior Treatments: _____

Other Health Concerns: _____

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 History: _____

Previous Chiropractic Care ____ Y ____ N Doctors Name:_____
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

Other Doctors seen in the last year: _____

List of Antibiotics your child has taken:
During the last six months: _____ Lifetime: _____

List of Other Prescription Medications your child has taken:
During the last six months: _____ Lifetime: _____

Vaccination History: _____

Prenatal History:
Name of Obstetrician / Midwife: _____
Complications during pregnancy? ____ Y ____ N List: _____
Ultrasounds during pregnancy? ____ Y ____ N Number: _____
Medications during pregnancy? ____ 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? _____
Introduced to solids at: _____months Cow's Milk at: _____months
Food / Juice Allergies or Intollerance: ____Y ____ N 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:_____
Hold Head Up: _____ Stand Alone:_____
Sit 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, etc.). Was this the case with your child? ____ Y ____ N
Is or has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ____ Y ____ N
List: _____
Has your child ever been involved in a car accident? ____ Y ____ N List:_____
Has your child ever been seen on an emergency basis?____ Y ____ N List: _____
Other traumas not described above? ____ Y ____ N List: _____
Prior Surgery? ____ Y ____ N List: _____
Menarche? ____ Y ____ N List: _____`_____

Childhood Diseases:
Rubella: ____ Y ____ N Age: _____ Rubeola:____ Y ____ N Age: _____
Whooping Cough: ____ Y ____ N Age: _____ Mumps: ____ Y ____ N Age: _____
Chicken Pox: ____ 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.

AUTHORIZATION FOR CARE OF A 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 Number: _____

Signed: _____ Witnessed:_____ Date_____