

Pediatric History Form

It is a pleasure to welcome you to our family of happy and healthy chiropractic practice members. 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 # _____

Address: _____ City: _____

State: _____ Zip: _____ Parent/ Guardian: _____

Referred by: _____

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? _____

Past prescription drugs/ dosage? _____

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

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 (circle one): Hospital Birthing Center Home

Birth Intervention (circle one): Forceps Vacuum Extraction Caesarian Section

If Caesarian Section, was it: ___Emergency or ___Planned (check one)

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

_____ Hold head up _____ Walk alone _____ Sit up

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: _____

Other traumas not described above? _____

Lifestyle- (please check what applies)

Does your child: eat health food products (organic products, etc.) drink water

take vitamins Type: _____ take probiotics

Exercise: none moderate daily heavy

Hobbies/ interests: _____

Is there anything else you would like us to know about your child? _____

Parent/ Guardian name: _____ Signature: _____