Today's Date_____/_____/_____

Shifting Tides
CHIROPRACTIC

Pediatric History Form Ages 0 – 7

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 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 health for your family.

Name _____ Date of Birth _____/_____/_____ Age____ Male/Female

Address _____ City_____ State_____ Zip_____

Cell Phone _____ Cellular Provider (for appointment reminders)_____

Home Phone _____ Email Address _____

Who may we thank for referring you? _____

Emergency Contact Name:_____ Phone:_____

Address_____

Reason for pursuing care: ○ maintenance ○ improved health ○ problem _____

Have you ever seen other doctors for these conditions? Yes / NO

If yes, Chiropractor /Medical doctor / Other_____

Who and When? _____

What were the results? Favorable / Unfavorable (Please explain) _____

Were X-rays/ MRI / or CT Scan taken within the last 2 years Yes/NO If yes when, and what area? _____

_____

Providers/Facility name and address_____

Check any of the following conditions that currently apply:

___ Ear infection	___ Asthma	___ Bed wetting	___ Other_____
___ Allergies	___ Chronic colds	___ Recurring fevers	
___ Colic	___ ADD/ADHD	___ Temper tantrums	___ Other_____
___ Seizures	___ Autism	___ Digestive problems	
___ Scoliosis	___ Headaches	___ Growing/ Back pains	

Pediatrician Name_____ Last visit _____

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

Number of doses of antibiotics your child has taken: Past 6 months_____ Total life time _____

List all Prescription, Over the Counter medications, Vitamins & Supplements currently on AND the reason for each.

N/A for none:_____

List any Past use of medications _____

Prenatal History

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 / Birth Center / Home

Birth intervention? Forceps / Vacuum Extraction / Caesarian Section- Emergency or Planned

Genetic disorders / disabilities? Y/N

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 you child able to:

_____ Respond to stimuli _____ Hold head up _____ Sit up

_____ Cross Crawl _____ Stand alone _____ Walk alone

According to the National Safety Council, approximately 50% of children fall from a high place during their first year of life (ex, a bed, changing table, down stairs).

Did your child have a fall similar? Y/N Explain_____

Has your child been involved in 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

Does your child eat health food products (organic etc.) Y/N Drink water Y/N Take probiotics Y/N

Take vitamins Y/N Type_____ Exercise: none / some / daily / heavy

Hobbies /Interest _____

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

_____