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's 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.

Whom may we thank for referring you to this office? ______________________________ Today's Date: _______________

Child's Name: __________________________________ Birth Date: _____-_____-_____ Age: ______ Sex: ______

Address: ____ City: ___________________________
State: _______ Zip:_________

Primary Guardian's Contact Information

Guardian's Name: _________________________________ Relationship: _______________________________________

Home Phone: _____________________________________ Work Phone: ____

Cell Phone: _______________________________________ Cell Carrier: ____

E-mail Address: ____

Preferred Method of Contact (circle): Email Home Phone Cell Phone

Child's Health History

Current Weight: _________lbs. Current Height: _____ft. _____in.

Reason for pursuing care: □ Maintenance □ Improved Health □ Problem: ___________________________________

Check any of the following conditions that currently apply:

_____Ear infections
_____Digestive problems
_____Bed wetting
_____ Car accident (Please include when)

Other doctors seen for this condition (Please include doctor's names and prior treatment):

_____Allergies _____Growing/ back pains _____ Autism _____ Scoliosis _____ ADHD/ADD

_____ Chronic Colds_____ Recurring Fevers_____ Seizures _____Other: ____

_____Tantrums _____ Headaches _____Colic_____ Asthma

Previous Chiropractic Care? □No □Yes

If yes, name doctor and last visit: ___________________________________

Name of Pediatrician and last visit: ____

Are you satisfied with the care your child has received at the pediatrician? ☐No ☐Yes

Number 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.) ______________________________

Prenatal History

Name of Obstetrician/ Midwife: ____

Location of birth: ☐Hospital: ______________________ ☐Birthing Center: _______________________ ☐Home

Complications during pregnancy/ delivery? ☐No ☐Yes If yes, explain: ______________________________

Ultrasounds during pregnancy? ☐No ☐Yes If yes, how many: ______________________________

Medications taken during pregnancy/ delivery? ☐No ☐Yes: ______________________________

Cigarette/ Alcohol use during pregnancy? ☐No ☐Yes If yes, how often: ______________________________

Birth Intervention (Please check all that apply): _____Forceps ______ Vacuum Extraction ______Caesarian Section

If Caesarian Section, was it: ______ Emergency ______ Planned

Genetic disorders/disabilities? ☐No ☐Yes: ______________________________

Birth Weight: ________________ Birth Length: ______________ APGAR Scores: _________-_________

Developmental History (to the best of your knowledge)

Your child's spine is vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). Spinal nerve interference can affect the following. At what age was your child able to:

Respond to stimuli: _________________ Cross Crawl: _________________ Stand alone: _________________

Respond to visual stimuli: _________________ Hold head up: _________________ Walk alone: _________________

According to the National Safety Council, approximately 50% of children fall headfirst 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? ☐No ☐Yes: ______________________________

Have there been any other traumas? ☐No ☐Yes: ______________________________

Has your child been involved in any sports? ☐No ☐Yes:______________________________

Has your child been seen by a physician on an emergency basis? ☐No ☐Yes: ______________________________

Hobbies/ interests:

____

Guardian name: ___________________________ Signature: _______________________________ Date: __________