Pediatric History Form

Culture CHIROPRACTIC

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 _____Cesarean 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: _____