Pediatric History Form

Patient Name_____ SS#_____
Name of Parents / Guardians_____
Address _____City _____State _____Zip_____
Home Phone_____ Work Phone_____ Email Address_____
Birth Date _____ Sex_____ Weight_____ Height_____ Number of siblings_____
Who referred you to us? _____
Reason for seeking chiropractic care**:**_____
Other Doctors seen for this condition with specialty: _____
Prior treatment and outcome: _____
Other Current Health Problems: _____

Symptoms: Please check any current or past problems your child has on the list below:

_Dizziness	_Allergies	_Diarrhea	_Broken bones
_ADHD	_Runny Nose	_Poor Appetite	_Sprains/Strains
_Backaches	_Itchy Eyes	_Hyperactivity	_Hernias
_Heart Condition	_Rashes	_Behavioral	_Neck Pain
_Chronic Earaches	_Unusual Moles	_Poor Memory	_Arm/Elbow Pain
_Diabetes	_Neuritis	_Insomnia	_Leg/Hip Pain
_Tuberculosis	_Digestive	_Nightmares	_Knee/Foot Pain
_Hypertension	_Sinus Trouble	_Bed Wetting	_Growing pains
_Fever/Chills	_Cough/Wheeze	_Pain Urinating	_Joint Pain
_Frequent Colds	_Chest Pain	_Convulsions	_Scoliosis
_Arthritis	_Constipation	_Paralysis	_Blood disorders
_Headaches	_Anemia	_Muscle Pain	_Stomach Aches
_Asthma	_Rheumatic Fever	_Fainting	_Other

Health History:
Family History of any of the above diseases? Who and what conditions?_____
_____
Name of Pediatrician: _____ Date of last visit _____
Medications and conditions being treated: _____
Has your child ever taken antibiotics? Y/N Condition treated: _____
Has your child been injured participating in contact sports (Soccer, Football, Martial Arts…) Y/N
If yes, describe (Sprain, Broken Bone, Head Trauma…) _____
Has your child ever been involved in a car accident? Y/N Date & Injuries _____
Has your child ever fallen head first from (Changing Table, Bed, Stairs…) Y/N _____
Other traumas not described above? Y/N Type & Date: _____
Prior surgery: Y/N Type and Date:_____ Menarche: Y/N Age:_____
Genetic disorders or disabilities: Y/N List: _____
Food allergies Y/N List_____

Prenatal History
Location of Birth: O Home O Birthing Center O Hospital O Stepchild O Adopted
Complications during pregnancy: Y/N List: _____
Ultrasounds during pregnancy: N Y Number: _____
Medications during pregnancy/delivery: Y/N List: _____
Cigarette / Alcohol use during pregnancy: Y/N
Birth intervention: O Forceps O Vacuum O Caesarian, Why?_____
Complications during delivery: Y/N List: _____
Birth weight_____ Birth length_____ APGAR scores: 1 min _____ 5 min _____

Feeding history
Breast Fed: Y/N How long'?_____ Formula fed: Y/N How long'?_____
Type:_____ Introduced to solids at _____ months. Cow's milk at _____ months
Food / juice allergies or intolerances Y/N List: _____

Developmental History
Sleep (Hrs per night) _____ Naps (number & lengths) _____ Problems sleeping _____

At what age was your child able to: Crawl __ Sit alone __ Stand alone __ Walk alone __ Say words __

Childhood Diseases
O Chicken Pox - Age ___ O Mumps - Age ___ O Rubella - Age ___ O Whooping cough - Age ___
O Measles - Age ___ O Meningitis - Age ___ O Tuberculosis - Age ___ O Other - Age _____

Vaccination History:
O HBV / Hep B (Hepatitis B) – Age __ O MMR (Measles, Mumps, Rubella) – Age __
O DTP or O DTaP (Diphtheria, Tetanus, Pertussis) – Age __ O Varicella (Chicken Pox) – Age __
O HbCV / Hib (H. influenzae type b conjugate) – Age __ O PCV (Pneumoccocal) – Age __
O OPV (Oral Polio Vaccine) or O IPV (Inactivated Poliovirus) – Age __
Adverse Reactions to Any Vaccine? Y/N List: _____

CONSENT TO CHIROPRACTIC CARE

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.
I, _____, being the parent or legal guardian of _____ hereby grant permission for my child to receive chiropractic care.

Signed _____Witnessed _____

Date _____