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 is any way we can make you and your family feel more comfortable. 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.

Patient Name_____
Address_____
City_____ State___ Zip_____ Phone Number_____
Birthdate _____ Sex ____Weight_____ Length _____
Referred By _____
Names of Parents/Guardians _____

Purpose For Contacting Us _____

_____
_____

Check any of the following conditions your child has suffered from during the last six months:

Ear Infection	Scoliosis	Seizures	Chronic Colds	Headaches
Asthma	Digestive problems	ADHD	Recurring Fevers	Growing Back Pains
Allergies	Bed Wetting	Car Accident	Temper Tantrums	Other_____

Previous Chiropractor(s)_____Date of Last Visit _____

Name of Pediatrician_____Date of Last Visit _____
Any pertinent medical history_____

Prenatal History:
Name of Obstetrician _____ ____Name of Midwife_____
Complications during pregnancy: Yes/No List _____
Medications during pregnancy: Yes/No List _____
Cigarette/Alcohol use during pregnancy: Yes/No List _____

Birth Intervention:
Forceps Yes/No
Vacuum Extraction Yes/No
Caesarian Section Yes/No

Complications During Delivery? Yes/No List_____
Genetic Disorders or Disabilities? Yes/No List_____

Feeding History
Breast Fed Yes/No How Long? _____
Formula Fed Yes/No How Long?_____

Developmental History
Have you seen delays or have concerns about any of the following:

_____respond to sound
_____stand alone
_____walk alone
_____Crawl
_____hold head up
_____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 (e.g. a bed or changing table or down the stairs). Was this the case with your child? Yes/No

List_____

Has your child been involved in any high impact or contact sports (e.g. soccer, football, baseball, etc…) Yes/No

List_____

Has your child ever been involved in a car accident? Yes/No

List_____

Has your child been seen on an emergency basis? Yes/No

List_____

Other traumas not described above? Yes/No

List_____

Authorization for Care of a Minor

I hereby authorize this office and its doctors to administer care to my child as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charge by this office.

Signed: _____Date: _____