



# Pediatric History

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 Information

(Please Print)

Today's Date \_\_\_\_\_ Referred by \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

SSN: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_

Sex  Female  Male Weight \_\_\_\_\_ Height \_\_\_\_\_ Grade \_\_\_\_\_

Name of Parents or Legal Guardian \_\_\_\_\_

Purpose for contacting us: \_\_\_\_\_

Have other doctors been seen for this condition?  Yes  No If yes, what doctor(s): \_\_\_\_\_  
\_\_\_\_\_ When? \_\_\_\_\_

Other Health Problems: \_\_\_\_\_

Please check any of the following conditions your child has suffered during the past 6 months:

- |   |   |  |                                       |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Ear Infections     | <input type="checkbox"/> Scoliosis          | <input type="checkbox"/> Chronic Colds   | <input type="checkbox"/> Headaches    |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD            | <input type="checkbox"/> Bed Wetting  |
| <input type="checkbox"/> Reoccurring Fevers | <input type="checkbox"/> Car Accident       | <input type="checkbox"/> Growing Pains   | <input type="checkbox"/> Back Pain    |
| <input type="checkbox"/> Seizures           | <input type="checkbox"/> Colic              | <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Other: _____ |

Does your Child have any Allergies? \_\_\_\_\_

Is there anything in your family history you feel we should know: \_\_\_\_\_

Child's Previous Chiropractor: \_\_\_\_\_ Last Adjustment: \_\_\_\_\_

Reason for visit: \_\_\_\_\_ Satisfied with care?  Yes  No

Name of Pediatrician: \_\_\_\_\_ Last Check-up: \_\_\_\_\_

Reason for visit: \_\_\_\_\_ Satisfied with care?  Yes  No

Do we have your permission to send the pediatrician progress and treatment notes?  Yes  No

Number of times your child has needed antibiotics \_\_\_\_\_ Within 6 months \_\_\_\_\_

Other prescription medications your child has needed \_\_\_\_\_

Within 6 months \_\_\_\_\_ Reason \_\_\_\_\_

Vaccination History \_\_\_\_\_

## ❖ Prenatal History

Name of Obstetrician/Midwife: \_\_\_\_\_

Complications during pregnancy?  Yes  No If yes, please list: \_\_\_\_\_

Complications during delivery?  Yes  No If yes, please list: \_\_\_\_\_

Ultrasounds during pregnancy?  Yes  No If yes, number: \_\_\_\_\_

Medications during pregnancy?  Yes  No If yes, list: \_\_\_\_\_

Medications during delivery?  Yes  No If yes, list: \_\_\_\_\_

Location of birth:  Hospital  Birthing Center  Home

Birth Intervention:  Forceps  Vacuum/Extraction  Cesarean Section- Planned/Emergency

Apgar Scores? \_\_\_\_\_ Birth weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_

Cigarette/Alcohol use during pregnancy?  Yes  No

Genetic Disorders or Disabilities?  Yes  No If yes, list: \_\_\_\_\_

## ❖ Feeding History

Breast Fed?  Yes  No If yes, how long? \_\_\_\_\_

Formula fed?  Yes  No If yes, how long? \_\_\_\_\_

Introduced solids at \_\_\_\_\_ months Cow's milk at \_\_\_\_\_ months

Food/Juice allergies or intolerances?  Yes  No If yes, list: \_\_\_\_\_

## ❖ Developmental History

During the following times 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 inference). At what age was your child able to:

Respond to Sound \_\_\_\_\_ Cross Crawl \_\_\_\_\_ Respond to Visual Stimuli \_\_\_\_\_

Stand Alone \_\_\_\_\_ Sit Up \_\_\_\_\_ Walk Alone \_\_\_\_\_

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

Was this the case with your child?  Yes  No

Is/has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, etc.)?  
 Yes  No If yes, list: \_\_\_\_\_

Has your child ever been involved in a car accident?  Yes  No If yes, list: \_\_\_\_\_

Has your child ever been seen on an emergency basis?  Yes  No If yes, list: \_\_\_\_\_

Other Traumas not described above:  Yes  No If yes, list: \_\_\_\_\_

Prior surgery:  Yes  No If yes, list: \_\_\_\_\_

### ❖ Childhood Diseases

Chicken Pox  Yes  No Age \_\_\_\_\_ Mumps  Yes  No Age \_\_\_\_\_

Whooping Cough  Yes  No Age \_\_\_\_\_ Rubella  Yes  No Age \_\_\_\_\_

Rubeola  Yes  No Age \_\_\_\_\_ Other  Yes  No Age \_\_\_\_\_

We are here to serve you and encourage you to ask questions, your participation is vital and will help determine your results.

### ❖ Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex  Female  Male

Insurance Company \_\_\_\_\_ ID # \_\_\_\_\_

Group # \_\_\_\_\_ Name of Employer \_\_\_\_\_

Address of Insured \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

DO YOU HAVE ADDITIONAL INSURANCE?  Yes  No IF YES, COMPLETE THE FOLLOWING:

Name of Insured \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Insurance Company \_\_\_\_\_ ID # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex  Female  Male

Group # \_\_\_\_\_ Name of Employer \_\_\_\_\_