



Pediatric History Form

Dear New Patient,

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: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____
Birth Date: _____ Sex: _____ Weight: _____ Height: _____
Name of Parents/Guardians: _____
Who may we thank for referring you to our office? _____

Purpose For Contacting Us? _____

Other Doctors Seen for this Condition: _____ Treatments: _____

Other Health Problems? _____

Check any of the Following Conditions Your Child has Suffered from During the Past Six Months:

Ear Infections Scoliosis Seizures Chronic Colds Headaches
 Asthma/Allergies Digestive Problems ADHD Recurring Fevers Growing/Back Pain
 Colic Bed Wetting Car Accident Temper Tantrum Other _____

Family History: _____

Previous Chiropractor: _____

Date of Last Visit: _____ Reason: _____

Name of Pediatrician: _____

Date of Last Visit: _____ Reason: _____

Are you Satisfied with the Care Your Child has Received There? _____ N _____ Y

Number of Doses of Antibiotics Your Child has Taken:

During the Past Six Months: _____, Total during His/Her Lifetime: _____

Number of Doses of Other Prescription Medications Your Child has Taken:

During the Past Six Months: _____, Total During His/Her Lifetime: _____ List: _____

Vaccination History: _____

Prenatal History:

Name of Obstetrician/Midwife: _____

Complications During Pregnancy? _____ N _____ Y, List: _____

Ultrasounds During Pregnancy? _____ N _____ Y, Number: _____

Medications During Pregnancy/Delivery? _____ N _____ Y, List: _____

Cigarette/Alcohol Use During Pregnancy: _____ N _____ Y
Location of Birth: _____ Hospital _____ Birthing Center _____ Home
Birth Intervention: _____ Forceps _____ Vacuum Extraction
_____ C-Section, Emergency or Planned?
Complications During Delivery? _____ N _____ Y, List: _____
Genetic Disorders or Disabilities: _____ N _____ Y, List: _____
Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

Feeding History:

Breast Fed: _____ N _____ Y, How long: _____
Formula Fed: _____ N _____ Y, How long: _____ Type: _____

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

Was this the case with your child? _____ N _____ Y

Is/has your child been involved in any high impact or contact type sports (i.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc?) _____ N _____ Y, List: _____

Has your child ever been involved in a Car Accident? _____ N _____ Y, List: _____

Has your child been seen on an Emergency Basis? _____ N _____ Y, List: _____

Other Traumas Not Described Above? Explain: _____

Prior Surgery: _____

Menarche: _____ N _____ Y, Age: _____

Childhood Diseases:

Chicken Pox	N/Y	Age _____	Mumps	N/Y	Age _____
Rubella	N/Y	Age _____	Whooping Cough	N/Y	Age _____
Rubeola	N/Y	Age _____	Other	N/Y	Age _____

**WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.**

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son/Daughter as they deem necessary.
I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company: _____ Policy # : _____

Name of Parent/Guardian on Insurance card: _____ Date of Birth: _____

Parent/Guardian Social Security #: _____ Date: _____

Signed: _____