

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? Yes ____ No ____ If yes, what Specialty? _____

Prior treatment and outcome: _____

Other Health Problems: _____

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

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Sprains/Strains |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Itchy Eyes | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Hernias |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Rashes | <input type="checkbox"/> Behavioral | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Unusual Moles | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Arm/Elbow Pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Leg/Hip Pain |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Digestive | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Knee/Foot Pain |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Cough/Wheeze | <input type="checkbox"/> Pain Urinating | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Convulsions/Paralysis | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Blood Disorders |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Stomach Aches |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ | |

Health History:

Name of Pediatrician: _____ Date of last visit: ____/____/____

Reason for visit: _____

Medications and conditions being treated: _____

Has your child ever taken antibiotics? Yes ____ No ____ If yes, condition treated: _____

Has your child ever been injured participating in contact sports (Soccer, Football, Martial Arts...) Yes ____ No ____

If yes, describe (Sprain, Broken, Head Trauma...) _____

Has your child ever been involved in a car accident? Yes ____ No ____ If yes, Date: ____/____/____ Injury: _____

Has your child ever fallen head first from (Changing Table, Bed, Stairs...) Yes ____ No ____

Other traumas not described above? Yes ____ No ____ If yes, Date: ____/____/____ Type of trauma: _____

Prior surgery: Yes ____ No ____ If Yes, Date: ____/____/____ Type of Surgery: _____

Menarche: Yes ____ No ____ Age: _____

Prenatal History:

Location of Birth: Home ___ Birthing Center ___ Hospital ___ Stepchild ___ Adopted ___

Complications during pregnancy: Yes ___ No ___ If yes, list complications: _____

Ultrasounds during pregnancy: Yes ___ No ___ If yes, number of ultrasounds: _____

Medications during pregnancy/delivery: Yes ___ No ___ If yes, please list: _____

Cigarette/Alcohol use during pregnancy: Yes ___ No ___

Birth intervention: Forceps ___ Vacuum ___ Caesarian ___ Why? _____

Complications during delivery: Yes ___ No ___ If yes, list complications: _____

Genetic disorders or disabilities: Yes ___ No ___ If yes, Please list: _____

Birth Weight _____ Birth Length _____ APGAR scores: 1 min _____ 5 min _____

Feeding History:

Breast Fed: Yes ___ No ___ If yes, how long: _____ Formula Fed: Yes ___ No ___ If yes, how long: _____

Type: _____ Introduced to solids at: _____ months. Cow's milk at _____ months.

Food/juice allergies or intolerances: Yes ___ No ___ If yes, please list: _____

Developmental History:

Sleep (Hrs per night): _____ Number of naps: _____ Length: _____ Problems Sleeping: _____

At what age was your child able to:

Crawl _____ Sit Alone _____ Stand Alone _____ Walk Alone _____ Say Words _____

Childhood Diseases:

Chicken Pox ___ - Age ___ Mumps ___ - Age ___ Rubella ___ - Age ___ Whooping Cough ___ - Age ___

Measles ___ - Age ___ Meningitis ___ - Age ___ Tuberculosis ___ - Age ___ Other _____ - Age ___

Vaccination History:

HBV/Hep B (Hepatitis B) ___ - Age _____ MMR (Measles, Mumps, Rubella) ___ - Age _____

DTP or DTaP (Diphtheria, Tetanus, Pertussis) ___ - Age _____ Varicella (Chicken Pox) ___ - Age _____

HbCV/Hib (H. Influenza type b conjugate) ___ - Age _____ PCV (Pneumococcal) ___ - Age _____

OPV (Oral Polio Vaccine) ___ - Age _____ or IPV (Inactivated Poliovirus) ___ - Age _____

Adverse Reactions to any vaccine? Yes ___ No ___ If yes, please 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 of legal guardian of _____

hereby grant permission for my child to receive chiropractic care.

Signed _____ Witness _____

Date _____