



PEDIATRIC HISTORY FORM

Child's Name: _____ S.S. # _____

Male / Female (circle one) Date of Birth: ___/___/___ Weight: _____ Height: _____

Parent/Guardian Name(s): _____

Address: _____ City: _____ State: _____

Zip: _____ Home Number: _____

Referred by: _____

Purpose for contacting our office? _____

Check any of the following conditions that apply:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD | <input type="checkbox"/> Recurring Fevers |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Growing/Back Pains | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Temper Tantrums |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Seizures | <input type="checkbox"/> Asthma | <input type="checkbox"/> Car Accident,
when? _____ |

Previous Chiropractic Care? YES / NO

Last Visit? ___/___/___

Name of Pediatrician: _____

Last Visit? ___/___/___

Are you satisfied with the care your child has received at the pediatrician? YES / NO

Number of does of antibiotics your child has taken: Past 6 months: _____ Lifetime: _____

Vaccination History: _____

Medications currently taking: _____

Prenatal History:

Complications during pregnancy / delivery? YES/NO If yes, list: _____

Ultrasounds during pregnancy? YES / NO, How many: _____

Medications taken during pregnancy/delivery? YES / NO, List: _____

Cigarette / Alcohol use during pregnancy? YES / NO Amount: _____

Location of Birth (circle one): Hospital Birthing Center Home

Birth Intervention (circle one): Forceps Vacuum Extraction Caesarian Epidural

None/Natural

If Caesarian Section, was it EMERGENCY / PLANNED. If emergency, please explain: _____

Genetic disorders/disabilities: YES / NO, List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores _____ - _____

(over)

Pediatric Form, cont.

Feeding History:

Breast Fed: YES / NO, How long? _____

Formula Fed: YES / NO, How long? _____

Introduced to solid foods at: _____ months, cows milk at: _____ months

Food/Juice allergies or intolerances? YES / NO, List: _____

Developmental History:

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 interference). At what age was your child able to:

_____ Respond to Stimuli	_____ Cross Crawl
_____ Respond to Visual Stimuli	_____ Stand Alone
_____ Hold Head Up	_____ Walk Alone
_____ 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 (i.e. bed, changing table, down stairs)

Did your child have a fall similar to what was described above? YES / NO, Explain: _____

Has your child been involved in any high impact or contact sports? YES / NO, List: _____

Has your child been seen by a physician on an emergency basis? YES / NO, if yes, List: _____

Other traumas not described above? _____

Has your daughter started her menstruation cycle? YES / NO, Age: _____

Childhood Diseases:

Chicken Pox: YES / NO, Age _____ Mumps: YES / NO, Age _____

Rubella: YES / NO, Age _____ Whooping Cough: YES / NO, Age _____

Rubeola: YES / NO, Age _____ Other: _____, Age _____

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