Pediatric History Form

Welcome,

It is a pleasure to welcome you to our office. We hope you will choose to join our family of happy and healthy practice members. 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.

NAME_____ SSN_____

ADDRESS_____CITY_____

STATE_____ ZIP_____ BIRTHDATE ____/____/____

HOME/CELL PHONE _____ WORK PHONE _____

EMAIL _____

GENDER _____ HEIGHT _____ WEIGHT _____

PARENTS/ GUARDIANS_____

If there are any symptoms or conditions what are they and how are they affecting your child?

_____

Other doctors seen for this condition? Yes No Doctor's name(s) and prior treatments:

_____

Does your child have any health problems? _____

Family health history: _____

Previous chiropractor: _____

Date of last visit ____/____/_____

Name of pediatrician: _____

Date of last visit ____/____/_____ reason _____

Are you satisfied with the care your child has received there? Yes No

Number of doses of antibiotics your child has taken during the past 6 months: _____ lifetime: _____

Number of doses of other prescription medications your child has taken during the past 6 months:_____ lifetime: _____

Names of medications: _____

Vaccination history: _____

FEEDING HISTORY

Breastfed Yes No How long: _____

Formula fed Yes No How long: _____ Type: _____

Introduced solids at _____ months, cow's milk at _____ months

Food / juice allergies or intolerances Yes No List: _____

DEVELOPMENTAL HISTORY

During the following times your child's spine is most vulnerable to stress and should be routinely 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 sound

_____Respond to visual stimuli

_____ Hold head

_____Sit up

_____Cross crawl

_____Stand alone

_____Walk alone

According to the National Safety Council, approximately 50% of children fall from a high place during their first year of life (e.g. 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 type sports (e.g. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? Yes No List: _____

Has your child been involved in a car accident? Yes No
Describe:_____

Has your child been seen on an emergency basis? Yes No Describe: _____

Other traumas not listed above? Yes No Describe: _____

Prior surgery Yes No List: _____

Menarche Yes No Age: _____

CHILDHOOD DISEASES

Chicken Pox Yes No Age: _____

Rubella Yes No Age: _____

Rubeola Yes No Age: _____

Mumps Yes No Age: _____

Whooping Cough 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.

Authorization for care of a 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 tha I am personally responsible for payment of all fees charged by this office.

Parent/Guardian Signature _____ Date ____/____/____