

PEDIATRIC HISTORY FORM

It is our 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: _____ S.S. #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE #: (____) _____

BIRTH DATE: _____ SEX: _____ WEIGHT: _____ HEIGHT: _____

NAME OF PARENTS/GUARDIANS: _____

REFERRED BY: _____

PURPOSE FOR CONTACTING US:

OTHER DOCTORS SEEN FOR THIS CONDITION: Y N

DR.'S NAME & PRIOR TREATMENT: _____

OTHER HEALTH PROBLEMS: _____

Please check any of the following conditions that your child has suffered from during the past six months:

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

PREVIOUS CHIROPRACTOR: _____ DATE OF LAST VISIT: _____

REASON FOR VISIT: _____

NAME OF PEDIATRICIAN: _____ DATE OF LAST VISIT: _____

REASON FOR VISIT: _____

ARE YOU SATISFIED WITH THE CARE YOUR CHILD HAS RECEIVED THERE? Y N

Number of antibiotics your child has taken:

IN THE PAST 6 MONTHS: _____ TOTAL DURING HIS/HER LIFETIME: _____

Number of other prescription medications your child has taken (Please List):

IN THE PAST 6 MONTHS: _____

TOTAL DURING HIS/HER LIFETIME: _____

VACCINATION HISTORY: _____

PRENATAL CARE

NAME OF OBSTRECIAN/MIDWIFE: _____

COMPLICATIONS DURING PREGNANCY: N Y, LIST: _____

ULTRASOUND DURING PREGNANGY: N Y, NUMBER: _____

MEDICATIONS DURING PREGNANCY: N Y, LIST: _____

CIGARETTES/ALCOHOL DURING PREGNANCY: N Y, LIST: _____

LOCATION OF BIRTH: HOSPITAL BIRTHING CENTER HOME

BIRTH INTERVENTIONS: FORCEPS VACUUM EXTRACTIONS
 CAESARIAN SECTION: PLANNED EMERGENCY

COMPLICATIONS DURING DELVIERY: N Y, LIST: _____

GENETIC DISORDERS OR DISABILITTIES: N Y, LIST: _____

BIRTH WEIGHT: _____ BIRTH LENGTH: _____ APGAR SCORE: _____

FEEDING HISTORY

BREAST FED: N Y, HOW LONG: _____

FORMULA FED: N Y, HOW LONG: _____ TYPE: _____

INTRODUCED TO SOLIDS AT: _____ MONTHS COWS MILK AT: _____ MONTHS

FOOD/JUICE ALLERGIES/INTOLERANCES: N Y, LIST: _____

DEVELOPMENT 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 interference). At what age was your child able to?

RESPOND TO VISUAL SOUND: _____ CROSS CRAWL: _____

RESPOND TO VISUAL STIMULI: _____ STAND ALONE: _____

HOLD HEAD UP: _____ SIT UP: _____ WALK ALONE: _____

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. a bed, changing table, down stairs, etc.) Was this the case with your child? Y N

Is/has your child been involved in any high impact or contact type sports (i.e. soccer, gymnastics, baseball, cheerleading, and 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 TRAUMA'S NOT DESCRIBED ABOVE: N Y, LIST: _____

PRIOR SURGERY: N Y, LIST: _____ MENARCHE: N Y, AGE: _____

CHILDHOOD DISEASES:

CHICKEN POX: N Y, AGE: _____ RUBELLA: N Y, AGE: _____

WHOOPIING COUGH: N Y, AGE: _____ RUBELOLA: N Y, AGE: _____

OTHER: _____ AGE: _____

We are here to serve you, and encourage you to ask to ask questions. Your participation is vital and will help to determine your results. I hereby authorize Healthy Living Chiropractic 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.

Signature of parent or guardian: _____ Date: _____