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: _____

Address: _____ City: _____

State____ Zip: _____ Home Phone: _____Cell Phone: _____

Birth Date: ____/____/_____ Sex: _____ Weight: _____ Height: _____

Referred By: _____

Names of Parents / Guardians: _____

Purpose for contacting us? _____

Other doctors seen for this condition: N____ Y____ Doctor's names and prior treatment: _____

_____

Other health problems? _____

Check any of the following conditions that your child has suffered from during the past 6 months.

() Ear Infections	() Scoliosis	() Seizures	() Chronic colds	() Colic
() Headaches	() Asthma	() Allergies	() ADHD	() Bed wetting
() Growing / Back pain	() Recurring Fevers		() Temper tantrums	
() Car Accident	() Digestive problems		() OTHER: _____	

FAMILY HISTORY: _____

Previous Chiropractor: _____ Date of Last Visit: _____/_____/_____

Reason: _____

Name of Pediatrician: _____ Date of Last Visit: _____/_____/_____

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? ____ NY____ List:_____

Medications during Pregnancy/Delivery? ____N____Y List:_____

Cigarette/Alcohol use During Pregnancy:_____N _____Y

Complications During Delivery: ____N ____Y List: _____

Cesarean Section N ____ Y ____ Emergency or Planned? _____

Birth Weight: _____ Birth Length: _____

FEEDING HISTORY:

Breast Fed: N ____ Y ____ How Long: _____

Formula Fed: N ____ Y ____ How Long: _____ Type: _____

Introduced to Solids at: _____ monthsCows' Milk at _____ months

Food / Juice Allergies or Intolerances: N ____ Y ____ List: _____

_____

DEVELOPMENTAL HISTORY:

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

____ Cross Crawl ____ Stand Alone ____ 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. 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? ____N ____Y List: _____

Prior Surgery: ____N ____Y List: _____

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 ____

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#: _____

Signed:_____ Witnessed:_____ Date:_____