



PEDIATRIC HISTORY FORM

Dear New Patient,

The human body is designed to be healthy. Throughout life, and even during pregnancy, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your child's nerve system, that can result in poor health. Following your exam, we will outline a course of care to not only begin to correct any layers of damage, but also to recover and maintain your child's health potential. We look forward to working with you to build better health for your family.

Name: _____ SS# _____ Birth Date _____
 Address: _____ City: _____ State: _____ Zip: _____
 Age: _____ Sex: _____ Weight: _____ Height: _____
 Name of Parent(s) (or Guardian(s)) _____ Home Phone _____
 Mother Work Phone # _____ Father Work Phone# _____
 Mother Cell Phone # _____ Father Cell Phone # _____

Purpose for contacting us? _____

Other Doctors seen for this condition _____ N _____ Y

Name of treating doctor: _____

Prior Treatments: _____

Other Health Problems: _____

Check any of the following conditions your child has suffered from during the past six months:

- | | | |
|---|---|---|
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Recurring Colds |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Seizures | <input type="checkbox"/> Growing/Back Pains |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Chronic Colds | |

Family History: (Arthritis, Cancer, Diabetes, Heart/Blood Pressure, etc.)

Previous chiropractor: _____

Date of last pediatrician visit: _____

Reason: _____

Are you satisfied with the care your child received there? _____ N _____ Y

Number of does of ANTIBIOTICS your child has taken:

During the past 6 months: _____ Total during his/her lifetime: _____

Number of doses of OTHER PRESCRIPTION MEDICATIONS your child has taken: _____

List: _____

Vaccination History: _____



PRENATAL HISTORY:

Name of Obstetrician/ Midwife: _____

Complications during pregnancy? (Was it long or difficult?) N Y

Explain: _____

Ultrasounds during pregnancy? N Y Number: _____

Medications during pregnancy/delivery? N Y List: _____

Cigarette/Alcohol use during pregnancy: N Y

Birth Intervention:

- | | |
|--|------------------------------------|
| <input type="checkbox"/> Forceps | <input type="checkbox"/> Breach |
| <input type="checkbox"/> Vacuum Extraction | <input type="checkbox"/> Emergency |
| <input type="checkbox"/> Ceasarian Section | <input type="checkbox"/> Planned |

Complications during delivery: N Y

Explain: _____

Genetic Disorders or Disabilities: N Y

Explain: _____

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

FEEDING HISTORY:

Breast Fed: N Y, How long: _____

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

Introduced to Solids: _____ Months Cow's Milk _____ Months

Food/Juice allergies or intolerances: N Y

Explain: _____

DEVELOPMENTAL 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 Sound | _____ Respond to Visual Stimuli | _____ Sit Up |
| _____ Cross Crawl | _____ Stand Alone | _____ Walk Alone |
| | _____ Hold Head 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, volleyball, cheerleading, martial arts, etc.)? N Y

Explain: _____



Has your child ever been involved in a car collision? N Y

Explain: _____

Has your child ever been seen on an emergency basis? N Y

Explain: _____

Other traumas not described above? N Y

Explain: _____

Prior surgery: N Y

Explain: _____

Menarche: N Y, Age: _____

Genetic disorders or disabilities: N Y

Explain: _____

Childhood Diseases:

Chicken Pox N Y Age: _____

Whooping Cough N Y Age: _____

Mumps N Y Age: _____

Rubeola N Y Age: _____

Rubella N Y Age: _____

Other N Y 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 MINOR

I hereby authorize this office and its Doctor 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.

Parent Signature _____ Date: _____