Pediatric Health History Form

Dear New Practice Member,

It is a ***pleasure*** to welcome you to our family of happy and healthy chiropractic 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.

Patient Name: _____ Email: _____
Address: _____ City: _____
State: _____ Zip: _____ Birth Date: _____ Sex: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
How did you hear about us? _____
Names of Parents/Guardians: _____

Reason for visit: _____
Other doctors seen for this condition: Yes _____ No _____
Doctor's Names/Prior Treatments: _____

Circle any of the following conditions your child has suffered from during the past 6 months:

Ear infections	Scoliosis	Seizures	Chronic Colds
Asthma/Allergies	Digestive Problems	ADHD	Recurring Fevers
Colic	Bed Wetting	Car Accident	Temper Tantrums
Headaches	Growing/Back pains	Other: _____	

Family History:
Previous Chiropractor: _____ Date of last visit: _____
Name of Pediatrician : _____ Date of last visit: _____
Reason: _____
Antibiotics – Number of doses your child has taken:
In last 6 months: _____ Total during lifetime: _____
Prescription medications – Number of doses your child has taken:
In last 6 months: _____ Total during lifetime: _____ Vaccination History: _____
_____

Prenatal History
Name of Obstetrician/Midwife: _____ Phone: _____
Complications during pregnancy Yes: _____ No: _____ List: _____
Ultrasounds during pregnancy Yes: _____ No: _____ #: _____
Medications during pregnancy/delivery Yes: _____ No: _____ List: _____
Location of birth: Hospital: _____ Birthing Center: _____ Home: _____

Birth Intervention

Forceps: _____ Vacuum Extraction: _____ Caesarian Section: Planned Emergency

Complications during delivery: Yes: _____ No: _____ List: _____

Genetic disorders or disabilities Yes: _____ No: _____ List: _____

Feeding History

Breast Fed: Yes: _____ No: _____ How long: _____

Formula fed: Yes: _____ No: _____ How long: _____

Introduced to solids at Month: _____ Cows milk at Month: _____

Allergies/Intolerance Yes: _____ No: _____ List: _____

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 _____ Hold Head Up _____ Cross crawl _____Walk alone

_____ Respond to Visual Stimuli _____ Sit up _____ Stand Alone

Has your child ever been involved in a car accident Yes: _____ No: _____ List: _____

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

Other traumas not described above Yes: _____ No: _____ List: _____

Prior Surgery Yes: _____ No: _____ List: _____

Childhood Diseases

Chicken Pox	Yes: _____ No: _____	Rubella	Yes: _____ No: _____
Rubella	Yes: _____ No: _____	Mumps	Yes: _____ No: _____
Whooping Cough	Yes: _____ No: _____		

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 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 Parent or Guardian: _____

Signature: _____ Date: _____