Pediatric History Form

Patient Name_____
Name of Parents / Guardians_____
Address _____City _____State _____Zip_____
Home Phone_____
Birth Date _____ Sex_____ Weight_____ Height_____ Number of siblings_____
Who referred you to us? _____
Reason for seeking chiropractic care**:**_____
Other Doctors seen for this condition Y/N Specialty: _____
Prior treatment and outcome: _____
Other Health Problems: _____

Symptoms: Please check any current or past problems your child has on the list below:

_ADHD	_Rashes	_Poor Memory	_Growing pains
_Backaches	_Digestive	_Insomnia	_Joint Pain
_Chronic Earaches	_Sinus Trouble	_Nightmares	_Scoliosis
_Fever/Chills	_Cough/Wheeze	_Bed Wetting	_Blood disorders
_Frequent Colds	_Chest Pain	_Sprains/Strains	_Stomach Aches
_Headaches	_Constipation	_Hernias	_Other
_Asthma	_Diarrhea	_Neck Pain	
_Allergies	_Poor Appetite	_Arm/Elbow Pain	
_Runny Nose	_Hyperactivity	_Leg/Hip Pain	
_Itchy Eyes	_Behavioral	_Knee/Foot Pain	

Health History:
Name of Pediatrician: _____Date of last visit _____
Reason for visit: _____
Has your child ever taken antibiotics? Y/N Condition treated:_____When?_____
Has your child been injured participating in contact sports (Soccer, Football, Martial Arts…) Y/N
If yes, describe (Sprain, Broken Bone, Head Trauma…) _____
Has your child ever been involved in a car accident? Y/N Date & Injuries _____
Has your child ever fallen head first from (Changing Table, Bed, Stairs…) Y/N, Age_____
Other traumas not described above? Y/N Type & Date: _____
Prior surgery: Y/N Type and Date:_____
Prenatal History:
Location of Birth: O Home O Birthing Center O Hospital O Stepchild O Adopted
Complications during pregnancy: Y/N List: _____
Ultrasounds during pregnancy: N Y Number: _____
Medications during pregnancy/delivery: Y/N List: _____
Cigarette / Alcohol use during pregnancy: Y/N

Birth intervention: O Forceps O Vacuum O Caesarian,
Why?_____

Complications during delivery: Y/N List: _____

Genetic disorders or disabilities: Y/N List: _____
Birth weight_____ Birth length_____ APGAR scores: 1 min _____ 5 min _____

Feeding history

Breast Fed: Y/N How long'?_____ Formula fed: Y/N How long?_____
Introduced to solids at _____ months. Cow's milk at _____ months
Food / juice allergies or intolerances Y/N List: _____

Developmental History

At hat age was your child able to: Crawl __ Sit alone __ Stand alone __ Walk alone __ Say words __

Childhood Diseases

O Chicken Pox - Age ___ O Mumps - Age ___ O Rubella - Age ___ O Whooping cough - Age ___
O Measles - Age ___ O Meningitis - Age ___ O Tuberculosis - Age ___ O Other - Age _____

Vaccination History:

Has your child been fully vaccinated? Y/N
Adverse Reactions to Any Vaccine? Y/N List: _____

Insurance

Will you be using insurance? Yes No. Ins. Company. _____Please allow us to photocopy card

Please list any and all concerns you have pertaining to your child's health

_____

_____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me or my child for further evaluation.

Patient/Guardian
Print name _____

Patient/Guardian
Signature _____ Date_____