

PEDIATRIC HISTORY FORM

Patient Name _____ SS# _____
Name of Parents / Guardians _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Email Address _____
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:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Itchy Eyes | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Sprains/Strains |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Rashes | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Hernias |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Unusual Moles | <input type="checkbox"/> Behavioral | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Arm/Elbow Pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Digestive | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Leg/Hip Pain |
| <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Cough/Wheeze | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Knee/Foot Pain |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Pain Urinating | <input type="checkbox"/> Growing pains |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Anemia | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Fainting | <input type="checkbox"/> Blood disorders |
| <input type="checkbox"/> Allergies | | | <input type="checkbox"/> Stomach Aches |
| | | | <input type="checkbox"/> Other |

HEALTH HISTORY:

Name of Pediatrician: _____ Date of last visit _____
Reason for visit: _____
Medications and conditions being treated: _____
Has your child ever taken antibiotics? Y/N Condition treated: _____
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 _____
Other traumas not described above? Y/N Type & Date: _____
Prior surgery: Y/N Type and Date: _____ Menarche: Y/N Age: _____

PRENATAL HISTORY

Location of Birth: Home Birthing Center Hospital Stepchild 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: Forceps Vacuum 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? _____
Type: _____ Introduced to solids at _____ months. Cow's milk at _____ months
Food / juice allergies or intolerances Y/N List: _____

DEVELOPEMENTAL HISTORY

Sleep (Hrs per night) _____ Naps (number & lengths) _____ Problems sleeping _____
At What 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:

O HBV / Hep B (Hepatitis B) – Age ___ O MMR (Measles, Mumps, Rubella) – Age ___
O DTP or O DTaP (Diphtheria, Tetanus, Pertussis) – Age ___ O Varicella (Chicken Pox) – Age ___
O HbCV / Hib (H. influenzae type b conjugate) – Age ___ O PCV (Pneumococcal) – Age ___
O OPV (Oral Polio Vaccine) or O IPV (Inactivated Poliovirus) – Age ___
Adverse Reactions to Any Vaccine? Y/N List: _____

INSURANCE

Do you have medical insurance? Y/N Insurance Company Name _____
Policy Number _____ Insurance Company Phone number _____
Insured's Name _____ Relationship to patient _____
Insured's DOB _____ Insured's SS# _____
Insured's Employer _____ Insured's Employee Address _____

CONSENT TO CHIROPRACTIC CARE

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.
I, _____, being the parent or legal guardian of _____ hereby grant
permission for my child to receive chiropractic care.

Signed _____ Witnessed _____

Date _____