Pediatric History Form

Date:____/____/____ Child's Name: _____
Parent/Guardian Names: _____
Address:_____
City:_____ State:_____ Zip Code:_____
Home Phone(parental):_____ Cell Phone: _____
Email address: _____
Whom may we thank for referring you to this office: _____

Birth Date: ____/____/____ Age:_____ Birth Weight:_____
Current Weight:_____ Sex: M F

REASON FOR PURSUING CHIROPRACTIC CARE

____ She/He is continuing ongoing care from another Chiropractor.
____ I recently had my spine checked and I see the value in getting my child checked.
____ I'm concerned about his/her health and I'm looking for answers.
____ I want to improve my child's immune function.
____ I have no idea why we're here. Please explain to me what you do for children.
____ She/He has a specific condition that concerns me.
Explain condition/symptom:

_____

_____

PRESENT HISTORY

In order to understand your child's current level of health, please check any of the following body signals which your child has or has had previously.

☐ Ear Infections ☐ Allergies ☐ Asthma ☐ Colic ☐ Chronic colds/cough
☐ Headaches ☐ ADHD ☐ Bed Wetting ☐ Seizures ☐ Recurring Fevers
☐ Constipation ☐ Diarrhea ☐ Rashes ☐ Scoliosis ☐ Car Accident(s)
☐ Stomach/Digestive ☐ Temper Tantrums ☐ Learning Disorder ☐ Sleeping Problems
☐ Other (please describe):_____

List Prescription or Over the Counter Medications Now Taken:

_____
_____

Known Allergies:

_____

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Immunization History:_____
How many prescriptions of antibiotics has your child taken in the last 6 months?_____
How many in his/her lifetime (estimate):_____

PRENATAL HISTORY
Adopted? _____ No _____ Yes
Complications during pregnancy? ____ No ____ Yes
List: _____
Ultrasounds during pregnancy? ____ No ____ Yes Number: ____
Medications/drugs/caffeine during pregnancy? ____ No ____ Yes
List: _____
Cigarette/Alcohol use during Pregnancy? ____ No ____ Yes
Location of Birth: ____ Hospital ____ Birthing Center ____ Home

BIRTH HISTORY
Birth Intervention:
____ Mother Induced ____ Mother Medicated (Pitocin, etc.) ____ Caesarian Section
____ Forceps ____ Vacuum Extracted ____ Baby given medication after delivery
Complications during delivery?
List: _____
Breast Fed? ____ No ____ Yes How Long? _____
Formula Fed? ____ No ____ Yes How Long? _____
Genetic Disorders / Disabilities? ____ No ____ Yes
List: _____

According to the National Safety Council, approximately 50% of infants fall head first form a high place (bed, changing table, down stairs etc.) during the first year of life.
Was this the case with your child? ____ No ____ Yes
List: _____
Is/has your child been involved in any high impact or contact type sports?(i.e., soccer, football, gymnastics, hockey, baseball, cheerleading, martial arts, etc.) ____ No ____ Yes
List: _____

**We are happy to bill your insurance as a courtesy. It is your responsibility to know the limits of your insurance policy and you are responsible for any balance not covered by insurance.*
**There is a $20 fee for missed appointments.*

AUTHORIZATION FOR CARE OF A MINOR

It is important that our patients and we have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called, we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our only objective is specific adjusting to correct vertebral subluxations. Your signature verifies that the information given in this form is complete and correct and that you accept for your child, if eligible, chiropractic care on this basis.

Parent/Guardian Signature:_____ Date:____/____/____