Pediatric History Form

WELCOME
It is a pleasure to welcome you to our office. We hope you will choose to join our family of happy and healthy practice members. Please let us know if there is any way that we can make you and your family members 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 you and your family.

Name:____

Address:____ City:________________________________

State:_________ Zip:__________________ Home Phone:_______________________________

Birthdate:_____/_____/_____ Email:______________________________

Sex:__________ Weight:_______ Height:_______________

Names of parents or guardians:____

If there are any symptoms or conditions what are they, and how are they affecting your child?

____

Other doctors seen for this condition? Y N, Doctor's name and prior treatments:

____

Does your child have any health problems?____

Family history:____

Previous chiropractor:____

Date of last visit_____/_____/_____

Name of pediatrician:______________________________ Date of last visit:_____/_____/_____

Reason:____

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

Number of doses of antibiotics your child has taken: last 6 months_______ lifetime _______

Number of doses of other prescription medications your child has taken:

Last 6 months_________ Lifetime_______ Names of medications:______________________
____

Vaccination history:____

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FEEDING HISTORY

Breast fed? Y N How long?____________
Formula fed? Y N How Long?____________ Type______________________________________
Introduced solids at___________months, cow's milk at_________months
Food/juice allergies or intolerances Y N, List____

DEVELOPMENTAL HISTORY

During the following times, your child's spine is the 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
_______Hold head
_______Sit up
_______Crawl
_______Stand alone
_______Walk alone

According to the National Safety Council, approximately 50% of children fall from a high place during their first year of life (e.g., bed, changing table, stairs). Did your child? Y N

Is or has your child been involved in any high impact sports? Y N List:_________________________
____

Has your child ever been involved in a car accident? Y N Describe:____________________
____

Has your child ever been seen on an emergency basis? Y N Describe:____________________
____

Other traumas not described above:____
____

Surgeries:____

Age at menstruation: _______ N/A

Childhood diseases:

Chickenpox	Y	N	Age_____	Mumps	Y	N	Age_____
Rubella	Y	N	Age_____	Whooping Cough	Y	N	Age_____
Rubeola	Y	N	Age_____	Other	Y	N	Age_____

We are here to serve you and encourage you to ask questions.
Your participation is vital and will help determine your results.

I hereby authorize this office and its doctor(s) to administer care to my son or daughter as they deem necessary. I clearly understand and agree that I am personally responsible for all fees charged by this office.

Signature___________________________________ Date_____________________________________