Pediatric History Form

Dear New Patient,
It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. 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.

Patient Name: _____ Health Number _____ V.C._____

Address: _____Postal Code: _____Birth Date: _____/_____/_____

Home Number: _____ Work Number: _____

Names of Parents/Guardians: _____

Purpose for Contacting Us:_____

Other doctors seen for this condition: ☐Yes ☐No

Doctor's Name & Prior Treatment_____

Other health problems?_____

Family History:_____

Previous Chiropractor: _____

Date of last visit: _____/_____/_____ Reason: _____

Name of Pediatrician: _____

Date of last visit: _____/_____/_____ Reason: _____

Are you satisfied with the care your child has received there: ☐ Yes ☐ No

Number of doses of antibiotics you child has taken:

During the past 6 months: _____ total during his/her lifetime: _____

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

During the past 6 months: _____ total during his/her lifetime: _____ List_____

Vaccination History: _____

Prenatal History:

Name of Obstetrician / Midwife: _____

Complications during pregnancy? ☐Yes ☐ No List: _____

Complications during delivery? ☐ Yes ☐No List: _____

Ultrasounds during pregnancy? ☐ Yes ☐ No List: _____

Medications during pregnancy / delivery ☐ Yes ☐ No List: _____

Location of birth: _____Home _____Hospital _____Birth center

Birth intervention: _____ Vacuum Extraction _____ Epidural

_____ Forceps _____ C-Section (__ emergency __ planned)

Apgar Scores: _____

Cigarette/alcohol use during pregnancy: ☐ Yes ☐ No

Genetic Disorders or disabilities: ☐ Yes ☐No List:_____

Birth Weight: _____ Birth Length: _____

Feeding History:

Breastfed: ☐ Yes ☐ No How Long: _____

Formula Fed: ☐ Yes ☐ No How Long: _____ Type: _____

Introduced: Solids at _____ Months Cows Milk at _____ Months

Food/Juice Allergies or Intolerances: ☐ 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 (spine nerve interference). At what age was you child able to:

___Respond to sound _____Cross crawl

___Respond to visual stimuli _____Stand alone

___Hold head up _____Walk alone

___Sit up

According to the national safety council, approximately 50% of children fall head first from a high place during their first year of life (ie. A bed, changing table, down stairs, Etc.) Was this the case with your child?
☐ Yes ☐ No

Is/Has your child been involved in any high impact or contact type sports (ie. Soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ☐ Yes ☐ No

List: _____

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: _____

Menarche: ☐ Yes ☐ No Age: _____

Childhood Diseases:

Chicken Pox ☐ Yes ☐ No Age: _____ Mumps ☐ Yes ☐ No Age: _____

Rubella ☐ Yes ☐ No Age: _____ Whooping Cough ☐ Yes ☐ No Age: _____

Rubeola ☐ Yes ☐ No Age: _____ Other ☐ Yes ☐ No Age: _____

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.

Signed Parent: _____ Witnessed: _____ Date:_____

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