

Whom may we thank for referring you to our office? _____

PEDIATRIC HISTORY FORM

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Today's Date ____/____/____

Name _____ Date of Birth ____/____/____ Social Security # ____-____-____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ Mothers mobile: _____ Fathers mobile: _____

Mother _____ DOB ____/____/____ Father _____ DOB ____/____/____

Pediatrician/Family MD _____ City & State _____ Last Visit: ____/____/____

Purpose of last visit _____

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____ Age: _____

Ever been under chiropractic care? No Yes: Who/When? _____

Who is responsible for this bill? Mother Father Other (*please explain*) _____

Insurance Company _____

PREGNANCY HISTORY:

Third Trimester Presentation: ____ Vertex ____ Breech ____ Transverse ____ Face/Brow

Type of Birth: ____ Normal Vaginal ____ Forceps ____ Cesarean ____ Suction Cap or Vacuum

Location: ____ Home ____ Hospital ____ Birthing Center ____ Other: _____

Problems during Pregnancy: _____

Problems during Labor/Delivery: _____

Was there presence of: ____ Jaundice? (Yellow) ____ Cyanosis? (Blue) ____ Congenital Anomalies/Defects?

If yes, please explain _____

INFANT HISTORY:

Infant feeding: ____ Breast ____ Bottle If Bottle; which Formula? _____

Number of Hours sleep per night _____ Quality of Sleep: ____ Good ____ Fair ____ Poor

List all **IMMUNIZATIONS** your child has had: _____

Has your child ever been treated at the emergency room? ____ If yes; please explain _____

Has your child ever been hospitalized? ____ If yes; please explain _____

Has your child ever had any Surgeries? ____ If yes; please explain _____

Is your child currently on any medication? ____ If yes; please list: _____

AT WHAT AGE DID THE CHILD:

Respond to sound _____

Follow an object with his/her eyes _____

Hold head up _____

Sit Alone _____

Crawl _____

Stand _____

Walk alone _____

AT WHAT AGE, IF EVER, DID CHILD SUFFER FROM THE FOLLOWING:

Chicken pox _____ Mumps _____ Measles _____ Rubella _____
Whooping Cough _____ Other: _____

HAS YOUR CHILD EVER SUFFERED FROM:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Ruptures/Hernia |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Reflux | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Backaches | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Allergies to _____ |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Allergies to _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Allergies to _____ |
| <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Walking Trouble | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Other: _____ |

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS:

- | | | |
|---|---|--|
| <input type="checkbox"/> Fall in baby walker | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall off skateboard or skates |
| <input type="checkbox"/> Fall from crib | <input type="checkbox"/> Fall off swing | <input type="checkbox"/> Fall off bicycle |
| <input type="checkbox"/> Fall from high chair | <input type="checkbox"/> Fall off slide | <input type="checkbox"/> Fall down stairs |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars | <input type="checkbox"/> Other: _____ |

Has your child ever sustained an injury playing organized sports? _____ If yes; please explain _____

Has your child ever sustained an injury in an auto accident? _____ if yes; please explain _____

FAMILY HISTORY:

Please indicate if your child or a family member has had any of the following: Write "C" for child, "F" for family member:

- | | | |
|-------------------------------|--------------------------------|----------------------|
| ____ Heart Disease | ____ Diabetes | ____ Stroke |
| ____ Cancer | ____ High / Low blood pressure | ____ Asthma |
| ____ Gastrointestinal disease | ____ Memory/mood disorder | ____ Thyroid problem |

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____ Wellness _____ Check-up _____ Other: _____
_____ Pain/Discomfort; explain _____
_____ Injury; explain _____

If due to Pain/Discomfort/Injury, please fill out:

- Onset** of Problem: Date ____/____/____ _____ Unknown _____ Gradual _____ Sudden
- Ever had** this problem **before**? No Yes If yes when? _____
- Any **bowel or bladder** problems since this problem began?: No Yes (*Describe*): _____
- Any **medication taken** for this problem? No Yes: _____
- Have you seen any **other doctors** for this problem? No Yes: _____
- How is this problem **NOW**: Rapidly Improving Improving Slowly About the Same Gradually Worsening On & Off

I hereby authorize this office and its Doctor(s) to administer care, as they so deem necessary to my son/daughter

Parent's or Legal Guardian's Signature

Date

Printed Name _____ Date _____ 20____

