PEDIATRIC HISTORY FORM

Full Name ______________________________________ SS# _____________________ Date _______________

Address ____

City _____________________________ State _____ Zip _______________ (H) Phone _____________________

Age ____ DOB ______________ Names of Parents / Guardians ____

How were you referred to our office? ______________________________

Have you ever received Chiropractic care? Y / N If yes, how long ago? ________________________________

Purpose For Contacting Us? ____

Other Doctors seen for this condition? Y / N If yes, Doctors Names and Prior treatments: ____________________

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Other Health Problems? ____

Check any of the following your child has experienced from during the past six months:

☐ Ear Infections	☐ Scoliosis	☐ Seizures	☐ Chronic Colds	☐ Car Accident
☐ Asthma / Allergies	☐ Digestive Problems	☐ ADHD	☐ Recurring Fevers	☐ Growing / Back Pains
☐ Colic	☐ Bed Wetting	☐ Headaches	☐ Temper Tantrums	☐ Other _____________

Family History: ____

Previous Chiropractor? Y / N If yes, Chiropractors Names: ____

Name of Pediatrician: ____

Date of Last visit: __________________ Reason for visit: ____

Number of doses of antibiotics your child has taken:

During the past six months ___________ Total during his / her lifetime _______________

Please list any other medications your child has taken: ____

Is your child current on all vaccinations? Y / N Please list the vaccines that he / she has taken: _______________

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Has your child had any reactions to his / her vaccinations? – not sleeping well, fever, high pitched screaming, change in behavior, etc. Y / N If yes, please explain: ____

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Prenatal History:

Name of Obstetrician / Midwife: ____

Complications during pregnancy? Y / N If yes please explain: ______________________________________

Ultrasounds during pregnancy? Y / N Number: _____________

Medications during pregnancy? Y / N List: ____

Cigarette / Alcohol use during pregnancy? Y / N

Location of birth: _________ Home ___________ Birthing Center __________ Hospital _________ Other

Birth Intervention: _______ Forceps ________ Ceasarian Section Emergency or Planned _______ Vacuum Extraction

Complications during delivery? Y / N If yes please explain: ____

Genetic Disorders or Disabilities? Y / N If yes please explain: ___________________________

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 If yes, please explain: ______________________

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Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a Chiropractor for prevention and early detection of vertebral subluxation. At what age was your child able to:

_______ Hold head up

_______ Sit up

_______ Walk alone

_______ Cross Crawl

_______ Stand alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (a bed, changing table, down stairs, etc.). Was this the case with your child? Y / N

Is / has your child been involved in any high impact or contact type sports (soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? Y / N If yes, please explain: ___________________________

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Has your child ever been involved in a car accident? Y / N List: _________________________

Has your child ever been seen on an emergency basis? Y / N List: _______________________

Other traumas not described above? Y / N List: _______________________________

Any surgeries? Y / N List: ____

Childhood Diseases:

Chicken Pox	Y / N Age ____	Mumps	Y / N Age ____
Rubella	Y / N Age ____	Whooping Cough	Y / N Age ____
Rubeola	Y / N Age ____	Other ____________________	

Wellness Chiropractic provides three types of care. The first is **Initial Intensive Care,** which addresses the most recent cause of your symptoms and usually reduces or eliminates the symptoms. Then begins **Reconstructive Care,** which corrects the years of damage that occurred when there were few or no symptoms. And finally, we offer a genuine approach to **Wellness Care**. All of these options will be explained at your report of findings and then you'll be able to begin a course of care that fits your health goals.

Notice to our new patients: It is our policy to collect payment for services as they are rendered until payment arrangements have been made and/or insurance is verified. I agree to pay for services rendered as the charge is incurred and will pay for today's visit with (circle one). Cash Check MC / Visa / Discover

In order to avoid a missed appointment fee of $25, please call in advance if you are unable to keep your appointment.

I authorize the Doctors and staff of this office to examine, x-ray, and provide care to my child as they deem necessary.

Guardian's Signature ____________________________________ Date ________________