



# 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. We look forward to working with you to build better health for your family.

Patient Name: \_\_\_\_\_ S.S.#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Work Phone: \_\_\_\_\_

Sex: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Referred By: \_\_\_\_\_

Names of Parents / Guardians: \_\_\_\_\_

## Purpose For Contacting Us ? \_\_\_\_\_

Other Doctors Seen for this Condition: \_\_\_\_\_ N \_\_\_\_\_ Y , Doctors' Names and Prior Treatments: \_\_\_\_\_

Other Health Problems ? \_\_\_\_\_

Check any of the Following Conditions Your Child has Suffered from During the Past Six Months:

- |   |   |                                       |   |   |
|---|---|---------------------------------------|---|---|
| <input type="checkbox"/> Ear Infections     | <input type="checkbox"/> Scoliosis          | <input type="checkbox"/> Seizures     | <input type="checkbox"/> Chronic Colds    | <input type="checkbox"/> Headaches            |
| <input type="checkbox"/> Asthma / Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD         | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Growing / Back Pains |
| <input type="checkbox"/> Colic              | <input type="checkbox"/> Bed Wetting        | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Temper Tantrums  | <input type="checkbox"/> Other _____          |

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 ? \_\_\_\_\_ N \_\_\_\_\_ Y

Number of Doses of Antibiotics Your Child has Taken:

During the Past Six Months: \_\_\_\_\_ , Total During His / Her Lifetime: \_\_\_\_\_

Number of Doses of Other Prescription Medications Your Child has Taken:

During the Past Six Months: \_\_\_\_\_ , Total During His / Her Lifetime: \_\_\_\_\_ List: \_\_\_\_\_

Vaccination History: \_\_\_\_\_

## Prenatal History:

Name of Obstetrician / Midwife: \_\_\_\_\_

Complications During Pregnancy ? \_\_\_\_\_ N \_\_\_\_\_ Y , List: \_\_\_\_\_

Ultrasounds During Pregnancy ? \_\_\_\_\_ N \_\_\_\_\_ Y , Number: \_\_\_\_\_

Medications During Pregnancy / Delivery ? \_\_\_\_\_ N \_\_\_\_\_ Y , List: \_\_\_\_\_

Cigarette / Alcohol Use During Pregnancy: \_\_\_\_\_ N \_\_\_\_\_ Y

Location of Birth: \_\_\_\_\_ Hospital \_\_\_\_\_ Birthing Center \_\_\_\_\_ Home