ABC CHIROPRACTIC

PEDIATRIC HISTORY FORM

Dear Parent,
It is our pleasure to welcome you to our family of happy and healthy Chiropractic practice members. Please let us know if there is any way we can make you and your family feel more comfortable. To help serve you better, please complete the following information.
We look forward to working with you and your family to build better health!

Name: ____ Birth Date: _____/_____/____
Sex: M F Weight: _________ Height: _______
S.S.# ______________________________
Referred by: ____

Address: ____
City: __________________________ State: ____________________ Zip: __________________
Home Phone: _________________ Work Phone: _______________Cell Phone: _____________

Names of Parents / Guardians:
____

Purpose for Contacting Us?
____

Other Doctors Seen for this Condition? Y N
Doctors' Names and Prior Treatment:
____
____
____

Other Health Problems?
____
____
____

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

() Ear Infections () Scoliosis () Seizures () Chronic Colds () Headaches
() Asthma/Allergies () Digestive Problems () Recurring Fevers () ADHD
() Growing/back pain () Colic () Bed Wetting () Temper Tantrums () Car Accident
() 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
Why or Why not? ____
Has your child been vaccinated: Y N
Age of first vaccination: ____

Number of doses of Antibiotics your child has taken:
During the past six months: _______________ Total during his/her lifetime: _____________ List:
____
____
____

Number of Prescription medications your child has taken:
During the past six months: _______________ Total during his/her lifetime: ___________
List: ____
____
____

Prenatal History:

Obstetrician/ Midwife:
____

Complications During Pregnancy? N Y
List: ____
Ultrasounds During Pregnancy? N Y How many? ____________
Medications During Pregnancy/Delivery? N Y
List:____
____
____

Cigarette/Alcohol use during pregnancy? N Y

Location of Birth: Hospital _______ Birthing Center _______ Home _________

Birth Intervention?
Forceps _____ Vacuum Extraction ______ Caesarian Section _____ Emergency or Planned
Complications During Delivery? N Y
List: ____
____
____

Genetic Disorders or Disabilities? Y N
List:
____
____
Birth Weight __________ Birth Length: ________________ APGAR Score: _____________
Feeding History:
Breast Fed? N Y How long? _______________
Formula Fed? N Y How long? _____________ Type? ____________________
Introduced to solids at: ___________________ Months
Cows milk at _________ Months
Food/Juice Allergies or Intolerances: N Y
List: _______________________________________

According to the National Safety Council, approximately 50% of all children fall head first from a high place during the first year of their life (i.e. a bed, changing table, stairs, etc.)
Was that true of your child? N Y
Explain:
____
____

Is/Has your child ever been involved in any high impact or contact type sports (i.e. soccer, football gymnastics, baseball, cheerleading, martial arts) ? Y N
List:
____
Has your child ever been involved in a car accident? N Y
List: __________________________________
Has your child ever been seen on an emergency basis? N Y
List: _________________________________
Other Traumas not described above: N Y
List:
____
____
____

Prior Surgery: N Y
List:____
____
____
____

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

Authorization for care of Minor

I hereby agree for this office and its Doctors to administer are to my son/daughter, as they may deem necessary.

I clearly understand and agree that I am personally responsible for payment for all fees charged by this office.

Signed: _______________________________________ Date: ___________________________
Witness: ______________________________________