Patient History Form - Pediatric

Date: _____

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 Information

Name _____ DOB _____

Sex *M F* Height _____ Weight _____

Address _____ City _____ State ____ Zip _____

Parent/Guardian Name _____ Relationship to Patient _____

Cell Phone _____ Email _____

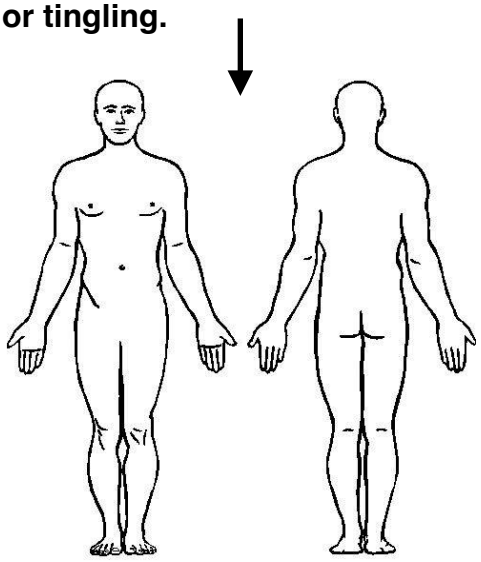
Insurance Type _____ **2ndary Insurance Type** _____

Patient Condition

Reason for visit _____

When did symptoms appear? _____ Is condition progressively worsening? *Yes No*

Mark an X on the picture where you continue to have pain, numbness or tingling.



Health History

What treatment has the child already received for the current condition?

medication PT chiropractic surgery none other: _____

Name of other practitioner(s) whom have treated this condition:

_____

Date of Last Visit To:

Chiropractor _____ Previous Chiropractor Name _____

Reason for visit _____

Pediatrician _____ Doctor Name _____

Reason for visit _____

Are you satisfied with the care you received? *Yes No* _____

Number of doses of antibiotics the child has taken: in last 6 mo _____ Lifetime _____

Number of other medications the child has taken: in last 6 mo _____ Lifetime _____

Current Medications: _____

Vaccination History: _____

Indicate if your child has had any of the following in the last 6 months:

Asthma	*Car Accident*	*Digestive Issues*	*Headaches*	*Seizures*
ADHD	*Chronic Colds*	*Ear Infections*	*Recurring Fevers*	*Temper Tantrums*
Bed Wetting	*Colic*	*Growing/Back Pains*	*Scoliosis*	*Allergies* _____

Family Health History: _____

_____

Prenatal History

Obstetrician Name _____ Medications _____

Complications During Pregnancy _____

How many Ultrasounds? _____ Cigarette/Alcohol Use? _____

Location of Birth: *Hospital* *Birthing Center* *Home* *Other* _____

Delivery: *Emergency* *Planned C-Section* *Normal*

Birth Intervention: *Forceps* *Vacuum Extraction* *C-Section* *N/A*

Complications: _____

Baby: Weight _____ Height_____ Apgar_____ Other_____

Feeding History

Breast Bottle Formula How long? _____ Type? _____ Age of 1st cow's milk? _____

Age of 1st solids?_____ Food/Juice Allergies: _____

Developmental History

During key developmental milestones, your child's spine is most vulnerable to stress and should routinely be checked by a doctor or chiropractor for prevention and early detection of vertebral subluxation (spinal nerve interference).

At what age was your child able to: *Respond to sound* ____ *Respond to visual stimuli* ____ *Hold head up* ____

Sit up _____ *Cross Crawl* _____ *Stand alone* _____ *Walk alone* _____

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

Is/has your child been involved in high impact or contact sports (soccer, football, gymnastics, baseball, cheerleading, martial arts, etc? *No* *Yes* _____

Has your child ever been involved in a car accident? *No* *Yes* *Please explain* _____

_____

Has your child ever been seen for an emergency? *No* *Yes* *Please explain* _____

_____

Other Traumas not listed above: _____

Surgeries: _____ Age: _____

Menarche Age: _____ N/A

Childhood Diseases

Age Occurred (or N/A): Chicken Pox ____ Rubella _____ Rubeola _____ Mumps _____Whooping Cough _____

Other _____