

PEDIATRIC HISTORY FORM

Patient Name: _____ S.S.# _____

Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____

Birth Date: ____/____/____ Sex: _____ Weight: _____ Height: _____' _____''

Referred By: _____ Parent/Guardian: _____

Parents' Work Phone #: _____ Alternate Phone #: _____

REASON FOR VISIT _____

Other Doctors seen for this condition: _____

Other Health Problems? _____

Check any of the following conditions your child has had in the last six months

- | | | | | |
|-------------------------------------------|---------------------------------------------|---------------------------------------|------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Ear Infection | <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 Fever | <input type="checkbox"/> Growing/Back Pain |
| <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: _____

Number of Doses (Times) Child has Taken Anitbiotics:

During the past six months: _____, Total During His/Her Lifetime: _____

List other Prescription Medications your child has taken: During the past six months: _____

Total During His/Her Lifetime: _____ List Medication Names: _____

Vaccination History: _____

Prenatal History:

Complications During Pregnancy? _____ Y _____ N List: _____

Ultrasounds During Pregnancy? _____ Y _____ N Approximate Number of Times: _____

Medications/Supplements During Pregnancy/Delivery? ___ Y ___ N

List: _____

Cigarette/Alcohol Use During Pregnancy: ___ Y ___ N

Location of Birth: (Circle One) Hospital / Birthing Center / Home Birth Intervention: Forceps: ___ Y ___ N

Vacuum Extraction: ___ Y ___ N Caesarean Section: ___ Y ___ N Circle One: Emergency or Planned?

Complications During Delivery? ___ N ___ Y, List _____

Genetic Disorders or Disabilities: ___ N ___ Y, List _____

Circle One: Breast / Formula Fed

Has Your Child Ever Been 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: _____

Prior Surgery: ___ Y ___ N List: _____

Childhood Diseases:

Chicken Pox N/Y, Age ___
German Measles N/Y, Age ___
Measles N/Y, Age ___

Mumps N/Y, Age ___
Whooping Cough N/Y, Age ___
Other N/Y, Age ___

AUTHORIZATION FOR CARE OF MINOR:

I hereby authorize this office and its Doctors to administer care to my Son/Daughter as they deem necessary, I clearly understand and agree that I am personally responsible for payment of all fees by this office.

Parent's Name: _____ Signature: _____

FOR OFFICE USE ONLY: Child's Name: _____

Today's Date: _____

Areas of Concern: _____

Dx: _____