PEDIATRIC HISTORY FORM

Patient Name________________________________ Name of Parents /Guardians_____________________________________
Address ____City ___________________________State _____Zip___________
Home Phone______________________ Work Phone_______________________ Email Address__________________________
SS#__________________________ Birth Date __________________ Sex_________ Weight___________ Height___________
Number of siblings_______ Who referred you to us? ____
Reason for seeking chiropractic care**:** ____
Other Doctors seen for this condition **Y/N** Specialty: ____
Prior treatment and outcome: ____
Other Health Problems: ____

Symptoms:

Please check any current or past problems your child has on the list below:

_Dizziness
_ADHD
_Backaches
_Heart Condition
_Chronic Earaches
_Diabetes _Tuberculosis
_Hypertension
_Fever/Chills
_Frequent Colds
_Arthritis
_Headaches
_Asthma
_Allergies

_Runny Nose
_Itchy Eyes
_Rashes
_Unusual Moles
_Neuritis
_Digestive
_Sinus Trouble
_Cough/Wheeze
_Chest Pain
_Constipation
_Anemia
_Rheumatic Fever

_Diarrhea
_Poor Appetite
_Hyperactivity
_Behavioral
_Poor Memory
_Insomnia
_Nightmares
_Bed Wetting
_Pain Urinating
_Convulsions _Paralysis
_Muscle Pain
_Fainting

_Broken bones
_Sprains/Strains
_Hernias
_Neck Pain
_Arm/Elbow Pain
_Leg/Hip Pain
_Knee/Foot Pain
_Growing pains
_Joint Pain
_Scoliosis
_Blood disorders
_Stomach Aches _Other

Health History:

Name of Pediatrician: ____ Date of last visit ___________________________________
Reason for visit: ____
Medications and conditions being treated: ____
Has your child ever taken antibiotics? **Y/N** Condition treated: ____
Has your child been injured participating in contact sports (Soccer, Football, Martial Arts…) **Y/N**
If yes, describe (Sprain, Broken Bone, Head Trauma…) ____
Has your child ever been involved in a car accident? **Y/N** Date & Injuries ____
Has your child ever fallen head first from (Changing Table, Bed, Stairs…) **Y/N** ____
Other traumas not described above? **Y/N** Type & Date: ____
Prior surgery: **Y/N** Type and Date: ________________________________ Menarche: **Y/N** Age: ________

Prenatal History:

Location of Birth: __ Home __ Birthing Center __ Hospital __ Stepchild __ Adopted
Complications during pregnancy: **Y/N** List: ____
Ultrasounds during pregnancy: **Y/N** Number: __________ Cigarette / Alcohol use during pregnancy: **Y/N** _________________
Medications during pregnancy/delivery: **Y/N** List: ____
Complications during delivery: **Y/N** List: ____
Genetic disorders or disabilities: **Y/N** List: ____
Birth weight________ Birth length_________ APGAR scores: 1 min _____ 5 min _____

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** List: ____

Developmental History:

Sleep (Hrs. per night) _______ Naps (number & length) _____________ Problems sleeping __________
At what age was your child able to: Crawl __ Sit alone __ Stand alone __ Walk alone __ Say words __

Childhood Diseases:

___Chicken Pox - Age ____ ___Whooping cough - Age ___ ___ Tuberculosis - Age ___

___Mumps - Age ________ ___Rubella - Age ___________ ___Measles - Age _______

___Meningitis - Age ______ ___ Other - Age ____________

Vaccination History:

___ HBV / Hep B (Hepatitis B) --Age ____
___DTP or ___DTaP (Diphtheria, Tetanus, Pertussis) – Age ___
___HbCV / Hib (H. influenzae type b conjugate) – Age _______
___OPV (Oral Polio Vaccine) – Age______
____MMR (Measles, Mumps, Rubella) – Age _________
____Varicella (Chicken Pox) – Age __________________
____PCV (Pneumoccocal) – Age ____________________
____IPV (Inactivated Poliovirus) – Age _______________
Adverse Reactions to Any Vaccine? Y/N List: ____

Insurance:

Do you have medical insurance? Y/N Insurance Company Name ____
Policy Number __________________________________ Insurance Company Phone number ___________________________
Insured's Name _________________________________ Relationship to patient _______________________________________
Insured's DOB __________________________________ Insured's SS# ____
Insured's Employer ______________________________ Insured's Employee Address__________________________________

CONSENT TO CHIROPRACTIC CARE

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.
I, ______________________________, being the parent or legal guardian of __________________________ hereby grant permission for my child to receive chiropractic care.

Signed ______________________________________Witnessed ____ Date ____________

APPOINTMENT CANCELLATION POLICY:

If you are unable to keep an appointment, as a courtesy to our staff and other patients, please give us **24 hours' notice**. We reserve the right to apply a **$25 charge** toward your account for each cancellation received less than 24 hours in advanced, "Late Cancellation Fee".

We also reserve the right to apply a **$45 charge** towards your account for each appointment missed when we did not receive prior notice (No Call, No Show). The patient will be responsible for payment regardless of future appointment schedule.

Patient's Signature: ____ Date: ___________________________