

**Pediatric Health History**

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents/Guardian Names \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date for birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_ Sex \_\_M\_\_F S.S.# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian's E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_

Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous Chiropractic Care? Y N When?\_\_\_\_\_\_Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_Who?\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check reasons for pursuing chiropractic care for your child

\_\_\_She/He is continuing ongoing care from another chiropractor

\_\_\_I recently had spine checked and I see the value in getting my child checked.

\_\_\_I'm concerned about his/her health and I am looking for answers.

\_\_\_She/He has a specific condition that concerns me.(briefly explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_I want to improve my child's immune function.

\_\_\_Wellness

In order for us to better understand your child's current level of health, please check any

of the following body signals which your child has or has had previously:

\_\_Headaches \_\_Postural \_\_Asthma \_\_Allergies

\_\_Ear infection \_\_Scoliosis \_\_ADD/ADH \_\_PDD/Autism

\_\_Seizures \_\_Growing Pains \_\_Back Pains \_\_Car accident \_\_Colic \_\_Frequent Colds \_\_Sinus Problems \_\_Bedwetting \_\_Digestive Problems

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List Prescription and Over The Counter Medications Now Taken:

Known Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of doses of Antibiotics Your Child has Taken:

During the past 6 months:\_\_\_\_\_\_\_\_\_

Total during his/her lifetime: \_\_\_\_\_\_\_

List reasons:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of doses of other Prescription Medications Taken:

During the past 6 months:\_\_\_\_\_\_\_\_\_

Total during his/her lifetime: \_\_\_\_\_\_\_

List reasons:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prenatal History

Adopted? \_\_\_Yes \_\_\_ No

Complications during pregnancy? \_\_\_Yes \_\_\_ No

List:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ultrasounds during pregnancy? \_\_\_Yes \_\_\_ No Number:\_\_\_\_\_\_

Medications/drugs/caffeine during pregnancy? \_\_\_ Yes \_\_\_ No

List:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cigarette / Alcohol use during pregnancy? \_\_\_ Yes \_\_\_ No

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

Birth Intervention

\_\_Mother induced \_\_Mother medicated (Pitocin, etc) \_\_Caesarian Section

\_\_Forceps \_\_Vacuum extracted

\_\_Baby given medications after delivery:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complications during delivery? \_\_Yes \_\_No List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Genetic disorders or disabilities? \_\_Yes \_\_No List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast Fed? \_\_\_\_Yes \_\_\_\_No How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Formula Fed? \_\_\_\_Yes \_\_\_\_No How long?\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Allergies or Intolerances?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

According to the National Safety Council, approximately 50% of children head fall first

from a high place during the first year of life. (i.e., a bed, changing table, down stairs, etc.)

Was this the case with your child? \_\_Yes \_\_ No

List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is/Has your child been involved in any high impact or contact type sports? (i.e., soccer,

football, gymnastics, hockey, baseball, cheerleading, martial arts, etc.) \_\_Yes \_\_ No

List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been seen on an emergency basis? \_\_Yes \_\_ No

List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior surgery? \_\_ Yes \_\_ No

List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

It is important that our patients and we have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe that the greatest Doctor is the one already inside each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept for your child, if eligible, chiropractic care on this basis.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent / Guardian Signature Date