PEDIATRIC HISTORY FORM

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 heath for your family.

Patient Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Birth Date: _____ / _____ / _____ Work Phone: _____

Sex: _____ Weight: _____ Height: _____ Referred By: _____

Names of Parents / Guardians: _____

Purpose for Contacting Us _____

Other Doctors Seen for this Condition: _____ N _____ Y , Doctors' Names and Prior Treatments: _____

_____

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	___ ADHD	___ Recurring Fevers	___ Growing / Back Pains
___ Colic	___ Bed Wetting	___ Car Accident	___ Temper Tantrums	___ 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

Number of Doses of Antibiotics Your Child has Taken:

During the Past Six Months: _____ , Total During His / Her Lifetime: _____ List: _____

Vaccination History: _____

Prenatal History:

Name of Obstetrician / Midwife: _____

Complications During Pregnancy ? _____N _____Y , List: _____

Ultrasounds During Pregnancy ? _____ N _____Y , Number: _____

Medications During Pregnancy / Delivery ? _____ N _____Y , List: _____

Cigarette / Alcohol Use During Pregnancy: _____ N _____ Y

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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: _____ N _____ Y , List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____ , _____

Feeding History:

Breast Fed: _____ N _____ Y , How Long: _____

Formula Fed: _____ N _____ Y , How Long: _____

Introduced to Solids at: _____ Months , Cows' Milk at _____ Months

Food / Juice Allergies or Intolerances: _____ N _____Y , List: _____

_____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic 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 (i.e., a bed, changing table, down stairs, ect.). Was this the case with your child ? _____N _____Y

Is / has your child been involved in any high impact or contact type sport (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Marital Arts, ect.) ? _____ N _____Y , List: _____

_____

Has your child ever been involved in a Car Accident ? _____ N _____ Y , List: _____

Has your child been seen on an Emergency Basis ? _____ N _____ Y , List: _____

Other Traumas Not Described Above ? _____ N _____ Y , List: _____

Prior Surgery: _____ N _____ Y , List: _____

Menarche: _____ N _____ Y , Age: _____

Childhood Diseases:

Chicken Pox	N / Y, Age _____	Mumps	N / Y, Age _____
Rubella	N / Y, Age _____	Whooping Cough	N / Y, Age _____
Rubeola	N / Y, Age _____	Other	N / Y, Age _____

If your child came to our office with a physical health concern, please answer the questions below.

What is the main reason your child is here today? _____

_____

When did this condition start? Do you remember anything different is what your child was doing at the time?

_____

_____

Does anything reduce the symptoms or pain? _____

Does anything increase the symptoms or pain? _____

_____

Has your child seen any other professionals for this problem? If so, what did they do and was it helpful?

_____

_____

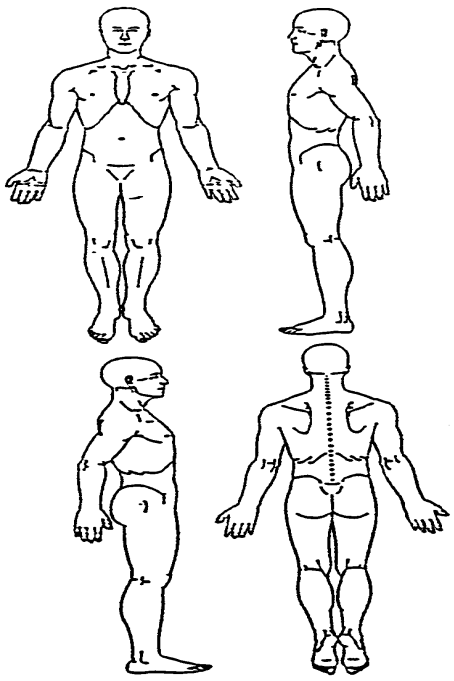
Has your child ever had this problem before or a similar problem? _____

_____

How would you describe the symptoms or pain? _____

_____

Can you mark on the diagram where the symptoms of pain are and if they travel can you mark that as well along with direction?



Are the symptoms constant or do they "come and go"? If constant, do the symptoms flare up? _____

_____

On a scale of 0-10 where 0 is no pain and 10 is the worst pain you can imagine, please rate the chief complaint:

When it began _____ How it is right now ____On average ____At its best _____At its worst _____

Have you noticed any pattern with the symptoms, such as time of day or after certain activities?

_____

_____

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Does your experience numbness____ or tingling____ and if so, where?_____

Does this condition wake your child up at night? _____

Are there any activities of daily living that they have difficulty with because of their condition (exp: brushing teeth, tying shoes, washing hair)? _____

_____

Are there any extended activities that they have difficulty with because of their condition (exp: driving car, work, hobby)? _____

To set clear expectations, improve communication and help you get the best results possible as quickly as possible, please read each statement below and initial your understanding/agreement.

_____ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this clinic is based on the best available evidence and designed to reduce or correct the primary condition (vertebral subluxation). Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

_____ I grant permission to be called/texted/emailed to confirm or reschedule appointments and to be sent occasional cards, letters, emails or health information as an extension of my care in this clinic.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Patient signature and date _____

If the patient is a minor child, print child's full name: _____

Doctor's initials _____