PEDIATRIC HISTORY FORM

DELIVERY/BIRTH HISTORY

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AT WHAT AGE DID THE CHILD:

RESPOND TO SOUND__________ FOLLOW AN OBJECT WITH HIS/HER EYES__________ HOLD HEAD UP__________

SIT ALONE _________ CRAWL _________ STAND _________ WALK ALONE _________

AT WHAT AGE, IF EVER, DID THIS CHILD SUFFER FROM THE FOLLOWING CHILDHOOD DISEASES?

CHICKEN POX _________ MUMPS _________ MEASLES _________ RUBELLA _________ RUBEOLA _________

WHOOPING COUGH _________ OTHER _________

HAS THIS CHILD EVER SUFFERED FROM:

HEADACHES ___	ORTHOPEDIC PROBLEMS ___	DIGESTIVE DISORDERS ___	BEHAVIORAL PROBLEMS ___
DIZZINESS ___	NECK PROBLEMS ___	POOR APPETITE ___	ADD/ADHD ___
FAINTING ___	ARM PROBLEMS ___	STOMACH ACHES ___	RUPTURES/HERNIA ___
SEIZURES ___	LEG PROBLEMS ___	REFLUX ___	MUSCLE PAIN ___
HEART TROUBLE ___	JOINT PROBLEMS ___	CONSTIPATION ___	GROWING PAINS ___
CHRONIC EARACHES ___	BACKACHES ___	DIARRHEA ___	ALLERGIES TO ___________
SINOUS TROUBLE ___	POOR POSTURE ___	DIABETES ___	ALLERGIES TO ___________
ASTHMA ___	SCOLIOSIS ___	HYPERTENSION ___	ALLERGIES TO ___________
COLDS/FLU ___	WALKING TROUBLE ___	ANEMIA ___	OTHER _________________
COLIC ___	BROKEN BONES ___	BED WETTING ___	OTHER _________________

HAS THIS CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS?

FALL IN BABY WALKER ___	FALL FROM BED OR COUCH ___	FALL OFF SKATEBOARD OR SKATES ___
FALL FROM CRIB ___	FALL OFF SWING ___	FALL OFF BICYCLE ___
FALL FROM HIGH CHAIR ___	FALL OFF SLIDE ___	FALL DOWN STAIRS ___
FALL FROM CHANGING TABLE ___	FALL OFF MONKEY BARS ___	OTHER _______________________________

HAS THIS CHILD EVER SUSTAINED AN INJURY PLAYING ORGANIZED SPORTS? ___ **IF YES, PLEASE EXPLAIN**: ________________
____

HAS THIS CHILD EVER SUSTAINED INJURIES IN AN AUTOMOBILE ACCIDENT? ___ **IF YES, PLEASE EXPLAIN**: ________________
____

HISTORY OF PRESENT COMPLAINT:

____
____
____

PLEASE LIST ALL SURGERIES: ____

LIST ALL MEDICATIONS: ____

FAMILY HISTORY: ____
____

PEDIATRIC HISTORY FORM

CHILD'S NAME ______________________________ MOTHER'S NAME ____________________________ DOB ______________

CHILD'S NICKNAME __________________________ FATHER'S NAME ____________________________ DOB ______________

ADDRESS: __________________________________ CITY: _______________________ STATE: ________ ZIP: _____________

HOME PHONE: _______________ MOTHER'S WORK PHONE: ________________ MOTHER'S CELL PHONE: _________________

EMAIL: _____________________ FATHER'S WORK PHONE: __________________ FATHER'S CELL PHONE: __________________

BIRTH DATE: ____ ____ ____ AGE: ___ SEX: ___ NUMBER OF SIBLINGS: ___ REFERRED BY: ________________________________

BIRTH WEIGHT: ___________ BIRTH LENGTH: __________ CURRENT WEIGHT: ____________ CURRENT HEIGHT: ____________

THIRD TRIMESTER PRESENTATION: VERTEX ____ BREECH ____ TRANSVERSE ____ FACE/BROW ____

TYPE OF BIRTH: NORMAL VAGINAL ____ FORCEPS ____ CESAREAN ____ SUCTION CAP OR VACUUM ____

LOCATION: HOME ____ HOSPITAL ____ BIRTHING CENTER ____ OTHER ____

PROBLEMS DURING PREGNANCY: ____

PROBLEMS DURING LABOR/DELIVERY: ____

APGAR SCORES: ____ ____ WAS THERE PRESENCE AT BIRTH OF: JAUNDICE (YELLOW)? ____ CYANOSIS (BLUE)? ____

CONGENITAL ANOMALIES/DEFECTS? ____ IF YES, PLEASE EXPLAIN? ____

INFANT FEEDING: BREAST ____ BOTTLE ____ IF BOTTLE, WHICH FORMULA? ____

NUMBER OF HOURS SLEEPING PER NIGHT: ________ QUALITY OF SLEEP: GOOD ____ FAIR ____ POOR ____

OBSTETRICIAN/MIDWIFE: ____

PEDIATRICIAN/FAMILY MD: ____

DATE OF LAST VISIT: _____________________ PURPOSE: ____

IMMUNIZATION HISTORY: ____

NUMBER OF DOSES OF ANTIBIOTICS YOUR CHILD HAS TAKEN: DURING THE PAST 6 MONTHS ____ DURING HIS/HER LIFETIME ____

PREVIOUS CHIROPRACTOR: ____

DATE OF LAST VISIT: _____________________ PURPOSE: ____

HAS YOUR CHILD EVER BEEN TREATED ON AN EMERGENCY BASIS? ____ IF YES, PLEASE EXPLAIN ____________________________

____

REASON FOR THIS APPOINTMENT: ____

INSURANCE/BILLING INFORMATION: ____POLICY # ____________________________

AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTOR(S) TO ADMNISTER CHIROPRACTIC CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR GUARDIAN).

SIGNED: ______________________________ PRINTED: ___________________________ RELATIONSHIP TO PATIENT _________________

WITNESSED: ___________________________ DATE: ____ ____ ____

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS OFFICE AND I AGREE TO PAY FOR ALL SERVICES PROVIDED. IF INSURANCE IS BILLED I AUTHORIZE THIS OFFICE TO USE PHI AS NECESSARY FOR THE PROCESSING OF CLAIMS.

SIGNED: ___________________________ PRINTED: ____________________________ DATE ____ ____ ____