**Pediatric History Form**

Date:\_\_\_\_/\_\_\_\_/\_\_\_\_ Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone(parental):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Social Security Number(just one):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you to this office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age:\_\_\_\_\_\_ Birth Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F

**REASON FOR PURSUING CHIROPRACTIC CARE**

**\_\_\_\_** She/He is continuing ongoing care from another Chiropractor.

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

\_\_\_\_ I’m concerned about his/her health and I’m looking for answers.

\_\_\_\_ I want to improve my child’s immune function.

\_\_\_\_ I have no idea why we’re here. Please explain to me what you do for children.

\_\_\_\_ She/He has a specific condition that concerns me.

Explain condition/symptom:

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

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

**PRESENT HISTORY**

In order to understand your child’s current level of health, please check any of the following body signals which your child has or has had previously.

**🞏 Ear Infections 🞏 Allergies 🞏 Asthma 🞏 Colic 🞏 Chronic colds/cough 🞏 Headaches 🞏 ADHD 🞏 Bed Wetting 🞏 Seizures 🞏 Recurring Fevers**

**🞏 Constipation 🞏 Diarrhea 🞏 Rashes 🞏 Scoliosis 🞏 Car Accident(s)**

**🞏 Stomach/Digestive 🞏 Temper Tantrums 🞏 Learning Disorder 🞏 Sleeping Problems**

**🞏 Other (please describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

List Prescription or Over the Counter Medications Now Taken:

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

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

Known Allergies:

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

Immunization History:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many prescriptions of antibiotics has your child taken in the last 6 months?\_\_\_\_\_\_\_

How many in his/her lifetime (estimate):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRENATAL HISTORY**

Adopted? \_\_\_\_\_ No \_\_\_\_\_ Yes

Complications during pregnancy? \_\_\_\_ No \_\_\_\_ Yes

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

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

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

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

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

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

**BIRTH HISTORY**

Birth Intervention:

\_\_\_\_ Mother Induced \_\_\_\_ Mother Medicated (Pitocin, etc.) \_\_\_\_ Caesarian Section

\_\_\_\_ Forceps \_\_\_\_ Vacuum Extracted \_\_\_\_ Baby given medication after delivery

Complications during delivery?

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

Breast Fed? \_\_\_\_ No \_\_\_\_ Yes How Long? \_\_\_\_\_

Formula Fed? \_\_\_\_ No \_\_\_\_ Yes How Long? \_\_\_\_\_

Genetic Disorders / Disabilities? \_\_\_\_ No \_\_\_\_ Yes

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

According to the National Safety Council, approximately 50% of infants fall head first form a high place (bed, changing table, down stairs etc.) during the first year of life.

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

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.) \_\_\_\_ No \_\_\_\_ Yes

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

**AUTHORIZATION FOR CARE OF A MINOR**

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 objective is specific adjusting to correct vertebral subluxations. 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:\_\_\_\_/\_\_\_\_/\_\_\_\_