



PEDIATRIC HISTORY FORM

Please print clearly and fill in completely

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 health for your family.

Patient Name: _____ Date _____

Address: _____
 Number Street City State Zip Code

Birthdate: _____ Weight: _____ Height: _____ Social Security# _____

Mother's Name _____ Father's Name _____

Male or Female _____ Home Phone _____

Cell Phone _____ Work Phone _____

Purpose of your Visit? _____

Other Doctors seen for this condition?: No Yes (If yes, please state doctors' names and prior treatments):

Other health problems? _____

Check any of the following conditions your child has suffered from during the past six months:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic Colds |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Headaches | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD/ADD |
| <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Colic | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Growing/Back Pains |
| <input type="checkbox"/> Car Accident | <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Autism | <input type="checkbox"/> Other: _____ |

Family History: _____

Previous Chiropractor: _____

Date of Last Visit: ____/____/____ Reason: _____

Name of Pediatrician/Family Doctor: _____

Date of Last Visit: ____/____/____ Reason: _____

Are you satisfied with the care your child has received there? Yes No

Number of doses of antibiotics your child has taken:

During the past six months: _____, total during his/her lifetime: _____ List: _____

Number of doses of other prescription medications 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? Yes No If yes, list: _____

Ultrasounds during pregnancy? Yes No If yes, number: _____

Medications during pregnancy/delivery? Yes No If yes, list: _____

Cigarette / Alcohol use during pregnancy? Yes No

Location of Birth: Hospital Birthing Center Home

Birth Intervention: Forceps Vacuum Extraction C-Section, Emergency or Planned? _____

Complications during delivery? Yes No If yes, list: _____

Genetic disorders or disabilities? Yes No If yes, list: _____

Birth Weight: _____ Birth Length: _____ APGAR scores, if known _____

Feeding History:

Breast fed Yes No If yes, how long? _____

Formula fed Yes No If yes, how long? _____

Introduced to solids at: _____ months old, cow's milk at _____ months/years

Food / Juice allergies or intolerances: Yes No If yes, 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 (spine nerve interference). At what age was your child able to:

_____ Respond to sound	_____ Cross crawl
_____ Respond to visual stimuli	_____ Stand alone
_____ Hold head up	_____ Walk alone
_____ Sit up	

According to the National Safety Council, approximately 50% of children fell head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.) Was this the case with your child? Yes No

Is / Has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.) Yes No If yes, list: _____

Has your child ever been involved in a car accident? Yes No If yes, list: _____

Has your child ever been seen on an emergency basis? Yes No If yes, list: _____

Other traumas not described above? Yes No If yes, list: _____

Prior surgery? Yes No If yes, list: _____

Menarche (first menstruation): Yes No Age: _____

Childhood Diseases:

Chicken Pox Yes No Age: _____
 Rubella Yes No Age: _____
 Rubeola Yes No Age: _____

Mumps Yes No Age: _____
 Whooping Cough Yes No Age: _____
 Other Yes No Age: _____

**WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.**

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Brown Chiropractic and its Doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all services rendered by this office.

(Parent/Guardian Printed Name)

(Parent/Guardian Signature)

(Date)

I authorize the release of any and all medical records or other information necessary to process claims. I also request payment of benefits be made directly to Brown Chiropractic. I am consenting to signing an open sign-in sheet every visit on behalf of my son/daughter and I understand that anyone who enters the office will be able to view his/her name on this sheet. The statements made on this form are accurate to the best of my recollection.

(Parent/Guardian Printed Name)

(Date)