courtley CHIROPRACTIC

# Pediatric History Form

(Please print, all information is confidential)

**Dear New Patient:**

It is our 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's Name: _____Referred by: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Ph: ____-____-____ Work Ph: ____-____-____ Cell Ph: ____-____-____ Other Ph: ____-____-____
E-mail: _____
Sex: M F DOB: _____/_____/_____ Age: _____ Weight: _____ Height: _____
Names of Parents / Guardians: _____
Do you have insurance? Y or N **(if yes, please give the front desk your card to copy)**

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Purpose for Contacting us? _____
Other doctors seen for this condition: ____Y ___N, Doctor's names and prior treatments:_____
_____
Other Health problems? _____

Check a11 of the following conditions your child has suffered from during the past six months:

| | | | |
|---|---|---|---|
| ☐ Ear Infections | ☐ Scoliosis | ☐ Bed Wetting | ☐ Chronic Colds |
| ☐ Asthma / Allergies | ☐ Digestive Problems | ☐ Seizures | ☐ Recurring Fevers |
| ☐ Colic | ☐ Growing / Back Pains | ☐ ADHD | ☐ Temper Tantrums |
| ☐ Headaches | | ☐ Car Accident | ☐ Other _____ |

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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? _____ Y _____N

Number of doses of Antibiotics your child has taken:
During the past six months: _____ Total during his/her lifetime: _____

Number of doses of Prescription Drugs your child has taken:
During the past six months: _____ Total during his/her lifetime: _____
Vaccination History: _____

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**Prenatal History:**
Name of obstetrician / midwife: _____
Complications during pregnancy? _____Y _____N, List: _____
Ultrasounds during pregnancy? _____Y _____N, Number: _____
Medications during pregnancy / delivery? _____Y _____N, List: _____
Cigarette/Alcohol use during pregnancy? _____Y _____N
Location of birth: _____ Hospital _____ Birthing Center _____ Home _____

Birth intervention: _____ Forceps _____ Vacuum extraction _____ C-Section, Emergency _____ or Planned _____?
Complications during delivery? _____Y _____N, List: _____
Genetic disorders or disabilities? _____Y _____N, List: _____
Birth Weight: _____ Birth Length: _____ APGAR Scores: _____ , _____

**Feeding History:**
Breast Fed: _____Y _____N, How long? _____
Formula Fed: _____Y _____N, How long? _____
Introduced to solids at: _____ Months, Cow's Milk at _____ Months
Food/juice allergies or intolerances: _____Y _____N, List: _____

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**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, etc.). Was this the case with your child? _____Y _____N

Is or has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? _____Y _____N, List: _____
_____

Has your child ever been involved in a car accident? _____Y _____N, List: _____
Other traumas not described above? _____Y _____N, List: _____
Prior surgeries: _____Y _____N, List: _____
Menarche: _____Y _____N, Age: _____

**Childhood Diseases:**

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Chicken Pox | Y | N | Age: _____ | Mumps | Y | N | Age: _____ | Rubella | Y | N | Age: _____ |
| Rubeola | Y | N | Age: _____ | Whooping cough | Y | N | Age: _____ | Other | Y | N | 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 MINOR**

I hereby authorize this office and its doctors to administer care to my son/daughter as they deem necessary. I do clearly understand and agree that I am personally responsible for payment of all fees charged by this office.
Signed: _____ Witnessed: _____ Date: _____/_____/_____