Where Health Comes First

Pediatric Health History

Name____Date ______________________________

Name of Parents / Guardians____

Address ______________________________ City ____________________State ________Zip__________

Home Phone_________________Other Phone____________________ Email _________________________

Birth Date ____________ Sex______ Weight____________ Height________ Number of siblings________

Who referred you to us? ____

Reason for seeking chiropractic care:____

Other Doctors seen for this condition Y/N Specialty: ____

Prior treatment and outcome: ____

Other Health Problems: ____

Symptoms: Please check any current or past problems your child has on the list below:

_Dizziness	_ADHD	_Backaches	_Heart Condition
_Chronic Earaches	_Diabetes	_Hypertension	_Fever/Chills
_Frequent Colds	_Arthritis	_Headaches	_Asthma
_Allergies	_Runny Nose	_Itchy Eyes	_Rashes
_Unusual Moles	_Neuritis	_Digestive	_Sinus Trouble
_Cough/Wheeze	_Chest Pain	_Constipation	_Anemia
_Rheumatic Fever	_Diarrhea	_Poor Appetite	_Hyperactivity
_Behavioral	_Poor Memory	_Insomnia	_Nightmares
_Bed Wetting	_Pain Urinating	_Convulsions	_Paralysis
_Muscle Pain	_Fainting	_Broken bones	_Sprains/Strains
_Hernias	_Neck Pain	_Arm/Elbow Pain	_Leg/Hip Pain
_Knee/Foot Pain	_Growing pains	_Joint Pain	_Scoliosis
_Blood disorders	_Stomach Aches	_Night Terrors	_Other________________________

Health History:

Name of Pediatrician: ______________________________________ Date of last visit ____________________

Reason for visit: ____

Medications and conditions being treated: ____

____

Has your child ever taken antibiotics? Y/N Condition treated: ____

Has your child been injured participating in contact sports (Soccer, Football, Martial Arts...) Y/N:
If yes, describe (Sprain, Broken Bone, Head Trauma...) ____
Has your child ever been involved in a car accident? Y/N Date & Injuries ________________________________
Has your child ever fallen head first? (from Changing Table, Bed, Stairs...) Y/N ____________________________
Other traumas not described above? Y/N Type & Date: ____
Prior surgery: Y/N Type and Date:____
Began Menstruating: Y/N Date: ____________________________

Prenatal History

Location of Birth: _ Home _ Birthing Center _ Hospital _ Adopted
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
Birth intervention: _ Forceps _ Vacuum _ Caesarian Why?____
Complications during delivery: Y/N Describe: ____
Genetic disorders or disabilities: Y/N Describe: ____
Birth weight__________ Birth length___________

Feeding History

Breast Fed: Y/N How long?_____________ Formula fed: Y/N How long?_____________ Type:____________
Introduced to solids at ______ months Cow's milk? Y/N At what age? ______________________
Food allergies or intolerances Y/N Describe: ____

Vaccination History:

Is your child vaccinated? Y/N
__Fully Vaccinated __Partially Vaccinated __Regular Schedule __Alternative Schedule
Adverse Reactions to Any Vaccine? Y/N List: ____

CONSENT TO CHIROPRACTIC CARE

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.
I, ____________________________________, being the parent or legal guardian of ________________________ hereby grant permission for my child to receive chiropractic care.
Signed ____Date ______________________________