Pediatric
Case History for...

_____

Pediatric History Form

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: _____ SS#: _____

Address: _____ City: _____

State: _____ Zip: _____ Home phone: _____

Date of birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Weight: _____ Height: _____

Parent(s) / Guardian(s): _____ Phone: _____

Referred by: _____

Reason(s) for seeking care: _____

Has another doctor been seen for this condition? ☐ Yes ☐ No If yes, whom: _____

Prior treatments: _____

Other health problems: _____

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

☐ Ear infection	☐ Scoliosis	☐ Seizures	☐ ADHD
☐ Headaches	☐ Asthma / allergies	☐ Digestive problems	☐ Bed wetting
☐ Recurring fevers	☐ Growing / back pains	☐ Colic	☐ Other: _____
☐ Car accident	☐ Temper tantrums	☐ Chronic colds	_____

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? ☐ Yes ☐ No

# of doses of **antibiotics** your child has taken: Past six months: _____ Total lifetime: _____

List antibiotics taken: _____

# of doses of **other prescription meds** your child has taken: Past six months: _____ Total lifetime: _____

List prescription medications taken: _____

Vaccination history: _____

Prenatal History

Name of obstetrician/midwife: _____

Complications during pregnancy: ☐ Yes ☐ No If yes, explain: _____

Ultra sounds during pregnancy: ☐ Yes ☐ No If yes, how many: _____

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

Cigarette/alcohol use during pregnancy: ☐ Yes ☐ No If yes, quantify: _____

Location of birth: ☐ Hospital ☐ Birthing center ☐ Home

Birth intervention: ☐ Vacuum extraction ☐ Forceps ☐ Cesarean extraction (☐ Emergency ☐ Planned)

Complications during delivery: ☐ Yes ☐ No If yes, explain: _____

Genetic disorders or disabilities: ☐ Yes ☐ No If yes, explain: _____

Birth weight: _____ Birth length: _____ APGAR scores: _____ & _____

Feeding History

Breast fed: ☐ Yes ☐ No If yes, how long: _____

Formula fed: ☐ Yes ☐ No If yes, how long: _____ Formula type: _____

Introduced to solids at: _____ months old; Cow milk at _____ months old

Food/juice allergies or intolerances: ☐ Yes ☐ No If yes, explain: _____

Development History

During the milestones listed below, your child's spine is most vulnerable to stress and should be routinely checked by a chiropractor 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, at some point, approximately 50% of children fall head first from a high place during their first year of life (e.g., bed, changing table, staircase, etc.). Has this happened to your child? ☐ Yes ☐ No

If yes, explain: _____

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

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

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

Are there any other traumas not described above? ☐ Yes ☐ No If yes, explain: _____

Prior surgery: ☐ Yes ☐ No If yes, explain: _____

Menstruation: ☐ N/A ☐ Yes ☐ No If yes, age started: _____

Childhood Diseases

Chicken pox: ☐ Yes ☐ No If yes, age: _____ Rubella: ☐ Yes ☐ No If yes, age: _____

Measles: ☐ Yes ☐ No If yes, age:_____ Mumps: ☐ Yes ☐ No If yes, age: _____

Whooping cough ☐ Yes ☐ No If yes, age: _____ Other: _____ Age: _____

We are here to serve you and encourage you to ask questions. Your participation is vital and will help determine the results for your child.

This consent was signed by:

_____ _____

Signature of patient or personal representative Date

_____

Name printed

_____

Description of personal representative's relationship to patient

Comments: (*office use only*)_____

_____

_____

_____