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PEDIATRIC HISTORY

Patient Name_____Prefers to be Called_____

Name of Parents / Guardians_____

Address_____City _____State _____Zip_____

Home Phone_____Work Phone_____ Email Address _____

Preferred contact _____ Child's Birth Date _____Sex_____

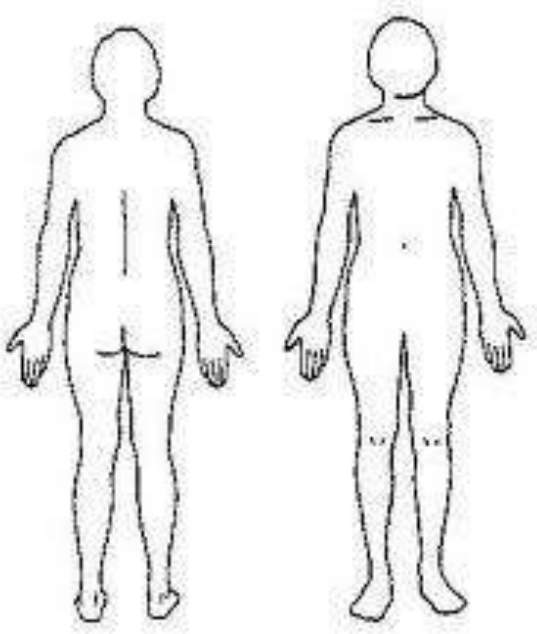
Weight_____Height _____Number of siblings_____

Who referred you to us? _____

Reason for seeking chiropractic care: _____

_____

Please mark any areas of pain or discomfort on the chart below:



Other Doctors seen for this condition? □ Y □ N Specialty: _____

Prior treatment and outcome: _____

Other Health Problems: _____

Have you had the same or similar condition before? □ Yes □ No If yes, when and describe:_____

_____

Symptoms: Please check any **C**urrent or **P**ast problems your child has on the list below:

___ADHD	___Constipation	___Headaches	___Nightmares
___Allergies	___Convulsions	___Heart Condition	___Pain Urinating
___Anemia	___Paralysis	___Hernias	___Poor Appetite
___Arm/Elbow Pain	___Cough/Wheeze	___Hyperactivity	___Poor Memory
___Arthritis	___Diabetes	___Hypertension	___Rashes
___Asthma	___Tuberculosis	___Insomnia	___Rheumatic Fever
___Backaches	___Diarrhea	___Itchy Eyes	___Runny Nose
___Bed Wetting	___Digestive	___Joint Pain	___Scoliosis
___Behavioral	___Dizziness	___Knee/Foot Pain	___Sinus Trouble
___Blood disorders	___Fainting	___Leg/Hip Pain	___Sprains/Strains
___Broken bones	___Fever/Chills	___Muscle Pain	___Stomach Aches
___Chest Pain	___Frequent Colds	___Neck Pain	___Unusual Moles
___Chronic Earaches	___Growing pains	___Neuritis	

Other: _____

_____

Health History

Name of Pediatrician: _____Date of last visit: _____

Reason for visit: _____

Medications and conditions being 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_____Menarche: □ Y □ N Age_____

Ear infections/colic/asthma □ Y □N Explain_____

Antibiotic usage □ Y □ N Conditions and dates (if known_____

Prenatal History

Location of Birth: O Home O Birthing Center O Hospital O Stepchild O Adopted

Any Complications during pregnancy: □ Y □ N List:_____

_____

Any Health Conditions during pregnancy: □ Y □ N List:_____

Ultrasounds during pregnancy: □ N □ Y Number:_____ Reason (if known)

_____

Medications during pregnancy/delivery: □ Y □ N List: _____

_____

Cigarette/Alcohol use during pregnancy: □ Y □ N Alcohol/wk _____#Cigs/wk_____

Did you use a midwife doula OB/MD (Circle all that apply)

Did your labor start naturally?_____or was it induced?_____

If induced, what medications were used?_____

How long did labor last? _____hrs. How would you describe it? _____

_____

Birth intervention: O Forceps O Vacuum O Caesarian

Why?_____

Complications during delivery: □ Y □ N List: _____

_____

Genetic disorders or disabilities: □ Y □ N List: _____

_____

Birth weight_____Birth length_____APGAR scores: 1 min _____5 min _____

Feeding History

Breast Fed: □ Y □ N How long?_____ Formula fed: □ Y □ N How long?_____

Type: _____Introduced to solids at_____mos. Cow's milk at_____mos.

Food / juice allergies or intolerances □ Y □ N List: _____

_____

Developmental History

Sleep (Hrs per night) _____Naps (# & lengths) _____Problems sleeping? □ Y □ N

If Yes, Please describe:_____

_____

At what age did your child: Crawl _____Sit alone _____Stand alone _____

Walk alone _____Say words _____

Childhood Diseases–check all that apply and include age of occurrence

O Chicken Pox – Age ___	O Measles – Age ___
O Mumps – Age ___	O Meningitis – Age ___
O Rubella – Age ___	O Tuberculosis – Age ___
O Whooping cough – Age ___	O Other – Age _____

Vaccination History–check all that apply and include age of occurrence

O HBV / Hep B (Hepatitis B) -- Age ___

OMMR (Measles, Mumps, Rubella) -- Age___

O DTP or DTaP (Diptheria, Tetanus, Pertussis) --Age___

O Varicella (Chicken Pox) -- Age ___

O OPV (Oral Polio Vaccine) or IPV (Inactivated Poliovirus) -- Age___

O HbCV/Hib (H. influenza type b conjugate) -- Age___

O PCV (Pneumoccocal) – Age ___

Adverse Reactions to Any Vaccine? □ Y □ N List: _____

_____

Family History

Family Diseases: check if applicable & indicate whether the family member is **F**ather, **M**other, **S**ister, **B**rother):

___ Tuberculosis ___ Diabetes ___ Stroke ___ Arthritis	___ Cancer ___ Asthma ___ Kidney Disease ___ Liver Disease	___ Mental Illness ___ Heart Disease ___ Lung Disease ___ Autoimmune Disease

Other_____

Insurance

Do you have medical insurance? Y/N Insurance Company Name _____

Policy Number _____Insurance Company Phone # _____

Insured's Name _____Relationship to patient _____

Insured's DOB _____Insured's SS# _____

Insured's Employer _____

Insured's Employee Address_____