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## PEDIATRIC HEALTH HISTORY

Name _____ Date _____

Names of Parents/Guardians _____

Address _____

City _____State _____ Zip _____

Home Phone _____ Other Phone _____

Email_____

Birth Date _____ Sex _____ Weight _____ Height _____ # of Siblings _____

Who referred you to us? _____

Reason for seeking chiropractic care: _____

Other doctors seen for this condition YES/NO Specialty: _____

Prior Treatment and Outcome: _____

Other Health Problems: _____

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

__Dizziness
__Chronic Ear Aches
__Frequent Colds
__Allergies
__Unusual Moles
__Cough/Sneeze
__Rheumatic Fever
__Behavioral
__Bed Wetting
__Muscle Pain
__Hernias
__Knee/Foot Pain
__Blood Disorders
__ADHD
__Diabetes
__Arthritis
__Runny Nose
__ Neuritis
__Chest Pain
__Diarrhea
__Poor Memory
__Pain Urinating
__Fainting
__Neck Pain
__Growing Pains
__Stomach Pains
__Backaches
__Headaches
__Itchy Eyes
__Digestive Issues
__Constipation
__Poor Appetite
__Insomnia
__Convulsions
__Broken Bones
__Arm/Elbow Pain
__Joint Pain
__Night Terrors
__Heart Condition
__Fever/Chills
__Asthma
__Rashes
__Sinus Trouble
__Anemia
__Hyperactivity
__Nightmares
__Paralysis
__Sprains/Strains
__Leg/Hip Pain
__Scoliosis
__Hypersensitivity
__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 participated in contact sports (Soccer, football, martial arts): Y/N _____

Has your child ever been involved in a car accident? Y/N Type and Date: _____

Has your child ever fallen head first? Y/N _____

Other traumas not described above? Y/N Type and Date: _____

Prior surgery: Y/N Type and Date: _____

Began Menstruating: Y/N Date: _____

**Prenatal History**

Location of Birth: __Home __Birth Center __Hospital __Adopted

Complications during pregnancy: Y/N List:_____

Ultrasounds during pregnancy: Y/N Number: _____

Medication 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 __Full __Partially __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 understand that chiropractic care is focused on the alignment and correction of vertebral subluxations and therefore, does not treat any specific condition otherwise.

I, _____(parent/guardian name), being the parent or legal

guardian of _____ (patient's name) hereby grant permission

for my child to receive chiropractic care.

Signed _____ Date _____