PEDIATRIC HISTORY FORM

Patient name_____ Parent/Guardian_____
Address _____City _____State _____Zip_____
Home phone_____ Email address_____
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 _Tuberculosis
_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 _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, etc.? Y/N
If yes, describe (sprain, broken bone, head trauma, etc.): _____
Has your child ever been involved in a car accident? Y/N Date & injuries: _____
Has your child ever fallen headfirst from changing table, bed, stairs, etc.? Y/N _____
Other traumas not described above? Y/N Type & date: _____
Prior surgery: Y/N Type and date: _____ First menses: Y/N Age: _____

Prenatal History:

Location of birth: __ Home __ Birthing Center __ Hospital __ Other
Complications during pregnancy: Y/N List: _____
Ultrasounds during pregnancy: Y/N Number: _____ Cigarette/alcohol use during pregnancy: Y/N _____
Medications during pregnancy/delivery: Y/N List: _____
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 _____ months. Cow's milk at _____ months
Food/juice allergies or intolerances Y/N List: _____

Developmental History:

Sleep (hrs. per night) _____ Naps (number & length) _____ Problems sleeping _____
At what age was your child able to: Crawl __ Sit alone __ Stand alone __ Walk alone __ Say words __

Childhood Diseases:

___Chicken pox - Age ____ ___Whooping cough - Age ___ ___ Tuberculosis - Age ___

___Mumps - Age _____ ___Rubella - Age _____ ___Measles - Age _____

___Meningitis - Age _____ ___ Other - Age _____

Vaccination History:

___HBV/Hep B (Hepatitis B) - Age ____ ____MMR (measles, mumps, rubella) – Age _____
___DTP or ___DTaP (diphtheria, tetanus, pertussis) – Age ___ ____Varicella (chicken pox) – Age _____
___HbCV/Hib (H. influenzae type b conjugate) – Age _____ ____PCV (pneumococcal) – Age _____
___OPV (Oral polio vaccine) – Age_____ ____IPV (inactivated poliovirus) – Age _____
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 _____Witnessed _____ Date _____

APPOINTMENT CANCELLATION POLICY:

If you are unable to keep an appointment, as a courtesy to our staff and other patients, please give us **24 hours' notice**. We reserve the right to apply a **charge** toward your account for each cancellation received less than 24 hours in advance - "Late Cancellation Fee".

We also reserve the right to apply a **charge** toward your account for each appointment missed when we did not receive prior notice - No Call, No Show. The patient will be responsible for payment regardless of future appointment schedule.

Signature: _____ Date: _____

TRUE VITALITY