



Pediatric History Form

Client name _____
 Parents /Guardians _____
 Address _____
 City _____ State _____ Zip _____
 Home Phone _____ Email _____
 Birth Date _____ Sex _____
 Weight _____ Height _____ # of siblings _____
 Whom may we thank for referring 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:

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Leg/Hip Pain |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Allergies | <input type="checkbox"/> Constipation | <input type="checkbox"/> Pain Urinating | <input type="checkbox"/> Knee/Foot Pain |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Growing pains |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Itchy Eyes | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Rashes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Unusual Moles | <input type="checkbox"/> Fainting | <input type="checkbox"/> Blood disorders |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Broken bones | <input type="checkbox"/> Stomach Aches |
| <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Digestive | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Other |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Behavioral | <input type="checkbox"/> Hernias | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cough/Wheeze | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Neck Pain | |
| <input type="checkbox"/> Headaches | | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Arm/Elbow Pain | |
| | | <input type="checkbox"/> Nightmares | | |

Health History:

Name of Pediatrician: _____
 Their phone number: _____
 Medications and conditions being treated: _____

Has your child 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 been involved in a car accident? Y/N
 Date & Injuries _____
 Has your child fallen head first from (Changing Table, Bed, Stairs...) Y/N _____
 Other traumas not described above? Y/N
 Type & Date: _____
 Prior surgery: _____
 Date of surgery: _____
 Menarche: Y / N Age: _____

Prenatal History

Location of Birth: Home Birthing Center Hospital
 Stepchild Adopted
 Complications during pregnancy: _____
 Cigarette / Alcohol use during pregnancy: Y/N
 Birth intervention: Forceps Vacuum Caesarian,
 Complications during delivery: _____
 Genetic disorders or disabilities: _____
 Birth weight _____ Birth length _____

Feeding history

BreastFed: Y/N _____ Formula Fed: Y/N _____
 Solids @ _____ Cow's milk at _____ months
 Food intolerances: _____

Developmental History

Sleep (Hrs/night) _____ Naps (# & time) _____
 Age child Crawled ___ Sat alone ___
 Stand alone ___ Walk alone ___ Say words ___

Childhood Diseases

Chicken Pox - Age ___ Mumps - Age ___
 Rubella - Age ___ Whooping cough - Age ___
 Measles - Age ___ Meningitis - Age ___
 Tuberculosis - Age ___ Other - Age ___

Vaccination History:

Please give a copy of child's vaccination card to our office.
 Any adverse Reactions to Any Vaccine? Y/N List: _____

Insurance

Do you have medical insurance? Y/N Insurance Company Name _____
 Policy Number _____
 Insurance Company Phone number _____
 Insured's Name _____
 Relationship to patient _____
 Insured's DOB _____
 Insured's SS# _____
 Insured's Employer _____
 Insured's Employee Address _____

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 _____