PEDIATRIC PATIENT HISTORY

Child's Name:_____ **SS#:**_____
Last **First** **MI**

DOB: _____ **Grade In School:** _____ **Sex:**_____ **Home Phone: (____)**_____

Address:_____ **City/Town:**_____ **State:**_____ **Zip:** _____

Mother's Name:_____ **Cell/Work Phone:** _____/_____
Last **First**

Father's Name:_____ **Cell/Work Phone:** _____/_____
Last **First**

Referred By:_____ **Purpose of this appointment:** _____

_____

_____

Pregnancy History (Mother)

(If the child is adopted, answer to the best of your ability)
Did you experience any of the following during your pregnancy:

- ❑ Severe viral infection during the first trimester
- ❑ Breech position during pregnancy
- ❑ Accident or Infections
- ❑ Smoking
- ❑ Severe stress
- ❑ Pre-eclampsia
- ❑ Alcohol consumption and/or drug use
- ❑ Radiation exposure
- ❑ Hypertension (high blood pressure)
- ❑ Toxoplasmosis
- ❑ Uncontrolled Diabetes
- ❑ Toxemia

Labor and Delivery History

Did you and/or the child experience any of the following during the labor/delivery:

- ❑ Hospital birth
- ❑ Birthing home
- ❑ Long and/or difficult labor
- ❑ Placenta previa
- ❑ Forceps or suction cup used
- ❑ Fetal distress
- ❑ Elective c-section
- ❑ The child was a "blue baby"
- ❑ Home birth
- ❑ The labor was induced
- ❑ The delivery was rapid
- ❑ Breech birth
- ❑ Cord around the neck
- ❑ Emergency c-section
- ❑ The child was premature (2+ weeks)

Comments:_____

_____

_____

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Newborn History
Did the child experience any of the following as a newborn:

- ❑ Required resuscitation/oxygen
- ❑ Prolonged jaundice
- ❑ Poor sleeper
- ❑ Immunizations in hospital
  If yes, specify vaccine:
- ❑ Distorted skull
- ❑ Difficulty latching/sucking
- ❑ Formula fed
- ❑ Breast fed
- ❑ Bottle fed
- ❑ Colic

Weight at birth:_____ Length at birth:_____

Health History
Has your child ever experienced the following or been diagnosed as having any of the following:

- ❑ Illnesses accompanied by a high fever
- ❑ Frequent headaches
- ❑ Seizures/Convulsions
- ❑ Chronic ear infections/earaches
- ❑ Head injury
- ❑ Serious fall(s) or repetitive falls
- ❑ Serious illness
- ❑ Epilepsy
- ❑ Meningitis
- ❑ Allergies to foods
- ❑ Environmental allergies
- ❑ Chemical insensitivities
- ❑ Undergone any surgeries
- ❑ Neck or back problems
- ❑ Adverse reaction to any vaccinations (even if mild)
  If yes, please explain:
- ❑ Dizziness
- ❑ Diabetes
- ❑ Hypoglycemia (low blood sugar)
- ❑ Trouble with bladder control (enuresis)
- ❑ Fainting
- ❑ High blood pressure
- ❑ Heart disease
- ❑ Asthma
- ❑ Sinus problems
- ❑ Constipation
- ❑ Diarrhea
- ❑ Digestive disorders
- ❑ Rheumatic Fever
- ❑ Joint or muscle problems

Developmental History
Does or did your child have any of the following:

- ❑ Difficulty with crawling (on all fours)
- ❑ Difficulty learning to ride a bike
- ❑ Difficulty learning to read
- ❑ Difficulty using utensils
- ❑ Difficulty tying shoes
- ❑ Poor hand-eye coordination
- ❑ Did not crawl on all fours
- ❑ Appears clumsy
- ❑ Difficulty with writing
- ❑ Difficulty buttoning clothing
- ❑ Difficulty or awkward with walking/running
- ❑ Difficulty sitting still or paying attention

At what age did your child start to walk unassisted: _____

Comments:_____
_____
_____

PEDIATRIC PATIENT HISTORY

Neurological/Other
Has your child ever been diagnosed by a medical professional with any of the following, if yes, by whom:

- ❑ Hearing loss or impairment
- ❑ Neurological disorders
- ❑ Obsessive Compulsive Disorder (OCD)
- ❑ ADD/ADHD
- ❑ Dyslexia
- ❑ Visual impairment
- ❑ Anxiety/Depression
- ❑ Autism/Autism Spectrum Disorder
- ❑ Tourette's Syndrome
- ❑ Other_____

Current/Past Medications and Treatment

List any medications that your child is taking:
List names, dosage, frequency
_____
_____

List any special dietary needs that your child has:
_____
_____
_____

List any supplements that your child takes:
_____
_____
_____

List any treatment that your child is currently undergoing with any health professional:
_____
_____

List any special services that your child is currently receiving at school or privately:
_____
_____
_____

List any previous chiropractic treatment, medications, or other medical treatment that your child has undergone:
_____
_____

Comments:_____
_____
_____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. _____, D.C. to evaluate and treat my son/daughter as they deem necessary.

I also acknowledge that I am financially responsible for any and all fees charged by this office and that payment will be made as services are provided. I also understand that any x-rays taken at this office are the property of this clinic.

_____ _____
Signature and relation of person completing this form **Date**

_____ _____
Signature of witness **Date**