CHIROPRACTIC FIRST

PEDIATRIC HISTORY FORM

Please print clearly and fill in completely

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: ______________________________ Date ______________

Address: ____

Number Street City State Zip Code

Birthdate: __________ Weight: __________ Height __________ Social Security# ______________

Mother's Name ______________________ Father's Name ______________________

Male or Female ______________________ Home Phone ______________________

Cell Phone ______________________ Work Phone ______________________

Purpose of your Visit? ______________ **Referred By** ______________________

Other Doctors seen for this condition?: No ☐ Yes ☐ (If yes, please state doctors' names and prior treatments):

____

____

Other health problems? ____

Check any of the following conditions your child has suffered from during the past six months:

☐ Ear Infections ☐ Scoliosis ☐ Seizures ☐ Chronic Colds

☐ Asthma/Allergies ☐ Headaches ☐ Digestive Problems ☐ ADHD/ADD

☐ Recurring Fevers ☐ Colic ☐ Bed Wetting ☐ Growing/Back Pains

☐ Car Accident ☐ Temper Tantrums ☐ Autism ☐ Other: ______________

Family History: ____

Previous Chiropractor: ____

Date of Last Visit: _____/_____/_____ Reason: ______________________________

Name of Pediatrician/Family Doctor: ______________________________

Date of Last Visit: _____/_____/_____ Reason: ______________________________

Are you satisfied with the care your child has received there? Yes ☐ No ☐

Number of doses of antibiotics your child has taken:

During the past six months: __________, total during his/her lifetime: __________ List: ______________

Number of doses of other prescription medications your child has taken:

During the past six months: __________, total during his/her lifetime: __________ List: ______________

Vaccination history: ____

____

Prenatal History:

Name of Obstetrician / Midwife: ______________________________

Complications during pregnancy? Yes ☐ No ☐ If yes, list: ______________________

Ultrasounds during pregnancy? Yes ☐ No ☐ If yes, number: ______________________

Medications during pregnancy/delivery? Yes ☐ No ☐ If yes, list: ______________________

Cigarette / Alcohol use during pregnancy? Yes ❑ No ❑

Location of Birth: ❑ Hospital ❑ Birthing Center ❑ Home

Birth Intervention: ❑ Forceps ❑ Vacuum Extraction ❑ C-Section, Emergency or Planned? _______________

Complications during delivery? Yes ❑ No ❑ If yes, list: ____

Genetic disorders or disabilities? Yes ❑ No ❑ If yes, list: ____

Birth Weight: _________________ Birth Length: _________________ APGAR scores, if known _____________, _____________

Feeding History:

Breast fed Yes ❑ No ❑ If yes, how long? ____

Formula fed Yes ❑ No ❑ If yes, how long? ____

Introduced to solids at: _________ months old, cow's milk at _____________________months/years

Food / Juice allergies or intolerances: Yes ❑ No ❑ If yes, list: ____

____

Developmental History:

During the following times, your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spine nerve interference). At what age was your child able to:

_____________________ Respond to sound _____________________ Cross crawl

_____________________ Respond to visual stimuli _____________________ Stand alone

_____________________ Hold head up _____________________ Walk alone

_____________________ Sit up

According to the National Safety Council, approximately 50% of children fell head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.) Was this the case with your child? Yes No

Is / Has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.) Yes ❑ No ❑ If yes, list: ____

Has your child ever been involved in a car accident? Yes ❑ No ❑ If yes, list: ______________________________

Has your child ever been seen on an emergency basis? Yes ❑ No ❑ If yes, list: ______________________________

Other traumas not described above? Yes ❑ No ❑ If yes, list: ____

Prior surgery? Yes ❑ No ❑ If yes, list: ____

Menarche (first menstruation): Yes ❑ No ❑ Age: __________

Childhood Diseases:

Chicken Pox	Yes ❑	No ❑	Age: __________	Mumps	Yes ❑	No ❑	Age: __________
Rubella	Yes ❑	No ❑	Age: __________	Whooping Cough	Yes ❑	No ❑	Age: __________
Rubeola	Yes ❑	No ❑	Age: __________	Other	Yes ❑	No ❑	Age: __________

WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Chiropractic First and its Doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all services rendered by this office.

_________________________________ _________________________________

(Parent/Guardian Printed Name) *(Parent/Guardian Signature)*

____

(Date)

I authorize the release of any and all medical records or other information necessary to process claims. I also request payment of benefits be made directly to Chiropractic First. I am consenting to signing an open sign-in sheet every visit on behalf of my son/daughter and I understand that anyone who enters the office will be able to view his/her name on this sheet. The statements made on this form are accurate to the best of my recollection.

_________________________________ _________________________________

(Parent/Guardian Printed Name) *(Date)*