

## Pediatric Health Form

Today's Date: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Patient's Name \_\_\_\_\_

Nickname \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex: M or F SSN#: \_\_\_\_\_

Parent/Guardian Names: \_\_\_\_\_

1<sup>st</sup> Contact Phone # \_\_\_\_\_ 2<sup>nd</sup> Contact Phone # \_\_\_\_\_

Mailing Address:

\_\_\_\_\_  
\_\_\_\_\_

Parent's E-mail (for patient Newsletter): \_\_\_\_\_

How Did You Hear About This Office? \_\_\_\_\_

Has He/She had previous Chiropractic Care: Y or N Doctor's Name: \_\_\_\_\_

Last Date of Visit: \_\_\_\_\_

### **Please check the reasons you are pursuing Chiropractic Care for your child:**

- ☐ He/She is continuing ongoing care from another chiropractor.  
☐ I recently had my spine checked and I see the value in getting my child checked.  
☐ I'm concerned about his/her health and I'm looking for answers.  
☐ He/She has a specific condition that concerns me.

Explain condition/symptom:

\_\_\_\_\_

☐ I want to improve my child's immune function.

☐ I have no idea why we're here. Please take the time to explain to me what you do for children.

**In order for us to better understand your child's current level of health, please check any of the following body signals which your child has or has had previously:**

- |                                        |                                             |                                             |                                     |
|----------------------------------------|---------------------------------------------|---------------------------------------------|-------------------------------------|
| <input type="checkbox"/> Headaches     | <input type="checkbox"/> Postural Imbalance | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Allergies  |
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Scoliosis          | <input type="checkbox"/> ADD/ADHD           | <input type="checkbox"/> Seizures   |
| <input type="checkbox"/> Car Accident  | <input type="checkbox"/> Growing/Back Pain  | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Colic      |
| <input type="checkbox"/> PDD/Autism    | <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Sinus Problems     | <input type="checkbox"/> Bedwetting |

Other:

\_\_\_\_\_  
\_\_\_\_\_



**Please List Prescription or over the counter medications your child is taking:**

**Known Allergies:** \_\_\_\_\_

**Number of doses of Antibiotics your child has taken:**

**During the past 6 months:** \_\_\_\_\_

**Total during lifetime:** \_\_\_\_\_

**List Reasons:** \_\_\_\_\_

**Number of doses of other Prescriptions Medications taken:**

**During the past 6 months:** \_\_\_\_\_

**Total during lifetime:** \_\_\_\_\_

**List Medications:** \_\_\_\_\_

**Prenatal History:**

Adopted? Y or N

Complications during Pregnancy? Y or N If so, List: \_\_\_\_\_

Ultrasounds during pregnancy? Y or N How many? \_\_\_\_\_

Medications/drugs/caffeine during pregnancy? Y or N If so, List: \_\_\_\_\_

Cigarette/Alcohol use during pregnancy? Y or N

Location of birth: \_\_\_Hospital \_\_\_Birthing Center \_\_\_Home

Birth Intervention:

\_\_\_Mother Induced \_\_\_Mother Medicated (Pitocin, etc) \_\_\_Caesarian Section \_\_\_Forceps

\_\_\_Vacuum Extracted \_\_\_Baby Given Medication after delivery – Type: \_\_\_\_\_

Complications during delivery? Y or N If so, List: \_\_\_\_\_

Genetic Disorders or Disabilities? Y or N If so, List: \_\_\_\_\_

Breast Fed? Y or N How Long? \_\_\_\_\_ Formula Fed? Y or N How Long? \_\_\_\_\_

Food Allergies or Intolerances? Y or N If so, List: \_\_\_\_\_

**According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (i.e., a bed, changing table, down the stairs, etc.). Was this the case with your child? Y or N**

If so, List: \_\_\_\_\_

Is/Has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, hockey baseball, cheerleading, martial arts, etc.)? Y or N

If so, List: \_\_\_\_\_

Has your child been seen on an Emergency basis? Y or N

If so, List: \_\_\_\_\_

Prior Surgery? Y or N

If so, List: \_\_\_\_\_

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**