

PEDIATRIC HISTORY FORM

Patient Name: _____ S.S.# _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Birth Date: ____/____/____ Work Phone: _____ Mother / Father

Sex: _____ Weight: _____ Height: _____ Referred By: _____

Names of Parents/Guardians: _____

Purpose For Contacting Us? _____

Other Doctors seen for this condition _____ N _____ Y. Doctor's 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 Headaches

Asthma/Allergies Digestive Problems ADHD Recurring Fevers Colic

Growing/Back Pains Bed Wetting Car Accident Temper Tantrums

Other: _____

Family History: _____

Previous Chiropractor: _____

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

Name of Pediatrician: _____

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

Number of doses of Antibiotics your child has taken:

During the past six months: _____. Total during his/her life _____

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

During the past six months: _____ Total during his/her life _____. List: _____

Prenatal History:

Name of Obstetrician/ Midwife: _____

Complications during pregnancy? _____ N _____ Y, List _____

Ultrasounds during pregnancy? _____ N _____ Y, Number _____

Medications during pregnancy/Delivery? (i.e. epidural) _____ N _____ Y, List _____

Cigarette/Alcohol use during Pregnancy? _____ N _____ Y

Birth History:

Location of the Birth: _____ Hospital _____ Birthing Center _____ Home

Birth intervention: _____ Forceps _____ Vacuum Extraction _____ C-Section _____

Complications during delivery? _____ N _____ Y, List: _____

Genetic Disorders or disabilities: _____ N _____ Y, List: _____

Birth weight: _____ Birth length: _____ APGAR Score: _____/_____

Feeding History:

Breast Fed: _____ N _____ Y, How Long? _____

Formula Fed: _____ N _____ Y, How Long? _____

Introduced Solids at: _____ Months, Cow's Milk at _____ Months

Food/Juice allergies or intolerances: _____ N _____ Y, List: _____

