Pediatric History Form

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. Many types of stressors (physical, mental, and chemical) can interfere with your child's growing brains, spine and nervous system. 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.

Child's Name: _____ Birth Date: ___/___/____

Male/ Female (Circle one) Weight: _____lbs. Height_____ft_____in. Phone #_____

Address:_____City:_____

State:_____ Zip:_____ Parent/ Guardian:_____

Referred by:_____

Reason for pursuing care: ☐ Maintenance ☐ Improved Health ☐ Problem:_____

Other Doctors seen for this condition? Y/ N Doctor's names and prior treatment:

_____

_____

List any other health problems: _____

Family history: _____

Check any of the following conditions that currently apply:

___ Ear infections	___ Scoliosis	___ Chronic colds	___ Headaches
___ Allergies	___ Digestive problems	___ ADHD/ADD	___ Recurring Fevers
___ Colic	___ Growing/ back pain	___ Bed wetting	___ Temper tantrums
___ Seizures	___ Asthma	___ Car accident: When?_____	

Other: _____

Previous Chiropractic Care? Y/ N Last Visit: ___/___/___

Name of Chiropractor: _____

Name of Pediatrician: _____ Last Visit: ___/___/___

# of Doses of antibiotics your child has taken: Past 6 months_____ Total lifetime _____

Present prescription drugs/ dosage? _____

Past prescription drugs/ dosage? _____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.) _____

Name of Obstetrician/ Midwife: _____

Complications during pregnancy/ delivery? Y/N Explain:_____

Ultrasounds during pregnancy? Y/N How many?_____

Medications taken during pregnancy/ delivery? Y/N List:_____

Cigarette/ Alcohol use during pregnancy? Y/N

Location of birth (circle one): Hospital Birth Center Home

Birth Intervention (circle one): Forceps Vacuum Extraction Caesarian Section

If Caesarian Section, was it: _____Emergency or _____ Planned (check one)

Genetic disorders/ disabilities? Y/N List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____-_____

Feeding History

Breast Fed: Y/N How long? _____ Formula Fed: Y/N How long? _____ Type:_____

Introduced to: Solid Foods @_____months Cow's milk @_____months

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

Developmental History

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 (spinal nerve interference). At what age was your child able to:

_____ Respond to stimuli _____ Cross Crawl _____ Stand alone

_____ Respond to visual stimuli _____Hold head up _____ Walk alone

_____ Sit up

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs)

Did your child have a fall similar to what was described above? Y/N
Explain:_____

Has your child been involved in any sports? Y/N List: _____

_____

Has your child been seen by a physician on an emergency basis? Y/N Explain:_____

_____

Other traumas not described above? _____

Lifestyle

Does your child: ☐ Eat health foods (organic products, etc.) ☐ Drink water

☐ Take vitamins Type: _____ ☐ Take probiotics

Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Hobbies/interests: _____

_____

Is there anything else you would like us to know about your child? _____

I understand that I am directly and fully responsible to Steadfast Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ *Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.*

_____ _____

Parent or Legal Guardian's Signature *Date*

Doctor Signature _____ *Date*_____

Please provide a list of anyone you give us permission to speak to about your Child's Health, Financials or both:

Please circle one of the following:

Name: _____ Relationship to child: _____ Health Financials Both

Name: _____ Relationship to child: _____ Health Financials Both