PEDIATRIC PATIENT HISTORY

CHILD'S NAME

LAST	FIRST	MI

DOB:	Grade	□ Male □ Female	Home Phone ( )

ST. ADDRESS	CITY	STATE	ZIP

MOTHER'S NAME

		( )
LAST	FIRST	CELL/WORK PHONE

FATHER'S NAME

		( )
LAST	FIRST	CELL/WORK PHONE

Referred By: _____ Reason For Visit:_____

_____

_____

Pregnancy History (Mother)

**If the child was adopted, answer to the best of your ability*

*Did you experience any of the following during your pregnancy***?**

Check all that apply

- □ 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:_____

_____

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: _____
_____
_____

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_____

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