Pediatric History Form

Date:_____ Referred by:_____

Patient Name _____
Parents Name(s)_____
Address _____City_____Zip_____
Phone_____ _____
DOB _____ Gender:____ Weight: _____ Height:_____

Purpose for contacting us: _____
Other Doctors seen for this condition (name and prior treatments:_____
_____
Previous Chiropractor:_____

List prescription medication_____
Vaccination history:_____
Circle Appropriately
Birth Place: Home/ Hospital/ Birth Center Type: Vaginal / C-Section
Procedures: Forceps/ Vacuum Extraction
Birth Complications: Y/N _____
Which sports does your child participate: Soccer/Football/Gymnastics/Hockey
Dance/Other:_____

Check any of the following conditions your child has suffered from in the past 6 mths:

__Ear infections __Scoliosis __Seizures __Chronic Colds __Headaches
__Asthma/Allergies __Colic __ADHD __Recurring Fevers __Bed Wetting
__Car Accident __Temper Tantrums __Digestive Problems _Other _____

Feeding History:
Breast Fed: Y/N, how long? ____ Formula Fed: N/Y?
Food/Juice allergies: list_____

Developmental History:
Is/has your child involved in high impact or contact sports? _____
Car Accident? When?_____
Ever been seen on an emergency basis? _____
Surgery? Y/N _____
Other traumas not listed above: Y/N _____

I hereby authorize this office and its doctor to administer care to my son/daughter as they deem necessary.

Parent's name: _____
Signature: _____ date: _____