

**Pediatric History Form**

Patient Name \_\_\_\_\_ SS# \_\_\_\_\_  
Name of Parents / Guardians \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email Address \_\_\_\_\_  
Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Number of siblings \_\_\_\_\_  
Who referred you to us? \_\_\_\_\_  
Reason for seeking chiropractic care: \_\_\_\_\_  
Other Doctors seen for this condition Y/N Specialty: \_\_\_\_\_  
Prior treatment and outcome: \_\_\_\_\_  
Other Health Problems: \_\_\_\_\_

**Symptoms:** Please check any current or past problems your child has on the list below:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Dizziness        | <input type="checkbox"/> Allergies       | <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Broken bones    |
| <input type="checkbox"/> ADHD             | <input type="checkbox"/> Runny Nose      | <input type="checkbox"/> Poor Appetite  | <input type="checkbox"/> Sprains/Strains |
| <input type="checkbox"/> Backaches        | <input type="checkbox"/> Itchy Eyes      | <input type="checkbox"/> Hyperactivity  | <input type="checkbox"/> Hernias         |
| <input type="checkbox"/> Heart Condition  | <input type="checkbox"/> Rashes          | <input type="checkbox"/> Behavioral     | <input type="checkbox"/> Neck Pain       |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Unusual Moles   | <input type="checkbox"/> Poor Memory    | <input type="checkbox"/> Arm/Elbow Pain  |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Neuritis        | <input type="checkbox"/> Insomnia       | <input type="checkbox"/> Leg/Hip Pain    |
| <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> Digestive       | <input type="checkbox"/> Nightmares     | <input type="checkbox"/> Knee/Foot Pain  |
| <input type="checkbox"/> Hypertension     | <input type="checkbox"/> Sinus Trouble   | <input type="checkbox"/> Bed Wetting    | <input type="checkbox"/> Growing pains   |
| <input type="checkbox"/> Fever/Chills     | <input type="checkbox"/> Cough/Wheeze    | <input type="checkbox"/> Pain Urinating | <input type="checkbox"/> Joint Pain      |
| <input type="checkbox"/> Frequent Colds   | <input type="checkbox"/> Chest Pain      | <input type="checkbox"/> Convulsions    | <input type="checkbox"/> Paralysis       |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Constipation    | <input type="checkbox"/> Muscle Pain    | <input type="checkbox"/> Blood disorders |
| <input type="checkbox"/> Headaches        | <input type="checkbox"/> Anemia          | <input type="checkbox"/> Fainting       | <input type="checkbox"/> Stomach Aches   |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Rheumatic Fever |   | <input type="checkbox"/> Other           |

**Health History:**

Name of Pediatrician: \_\_\_\_\_ Date of last visit \_\_\_\_\_  
Reason for visit: \_\_\_\_\_  
Medications and conditions being treated: \_\_\_\_\_  
Has your child ever taken antibiotics? Y/N Condition treated: \_\_\_\_\_  
Has your child been injured participating in contact sports (Soccer, Football, Martial Arts...) Y/N  
If yes, describe (Sprain, Broken Bone, Head Trauma...) \_\_\_\_\_  
Has your child ever been involved in a car accident? Y/N Date & Injuries \_\_\_\_\_  
Has your child ever fallen head first from (Changing Table, Bed, Stairs...) Y/N \_\_\_\_\_  
Other traumas not described above? Y/N Type & Date: \_\_\_\_\_  
Prior surgery: Y/N Type and Date: \_\_\_\_\_ Menarche: Y/N Age: \_\_\_\_\_

**Prenatal History**

Location of Birth:  Home  Birthing Center  Hospital  Stepchild  Adopted  
Complications during pregnancy: Y/N List: \_\_\_\_\_  
Ultrasounds during pregnancy: N Y Number: \_\_\_\_\_  
Medications during pregnancy/delivery: Y/N List: \_\_\_\_\_  
Cigarette / Alcohol use during pregnancy: Y/N  
Birth intervention:  Forceps  Vacuum  Caesarian, Why? \_\_\_\_\_  
Complications during delivery: Y/N List: \_\_\_\_\_  
Genetic disorders or disabilities: Y/N List: \_\_\_\_\_  
Birth weight \_\_\_\_\_ Birth length \_\_\_\_\_ APGAR scores: 1 min \_\_\_\_\_ 5 min \_\_\_\_\_

**Feeding history**

Breast Fed: Y/N How long? \_\_\_\_\_ Formula fed: Y/N How long? \_\_\_\_\_  
Type: \_\_\_\_\_ Introduced to solids at \_\_\_\_\_ months. Cow's milk at \_\_\_\_\_ months  
Food / juice allergies or intolerances Y/N List: \_\_\_\_\_

**Developmental History**

Sleep (Hrs per night) \_\_\_\_\_ Naps (number & lengths) \_\_\_\_\_ Problems sleeping \_\_\_\_\_  
At hat age was your child able to: Crawl \_\_ Sit alone \_\_ Stand alone \_\_ Walk alone \_\_ Say words \_\_

**Childhood Diseases**

Chicken Pox - Age \_\_\_  Mumps - Age \_\_\_  Rubella - Age \_\_\_  Whooping cough - Age \_\_\_  
 Measles - Age \_\_\_  Meningitis - Age \_\_\_  Tuberculosis - Age \_\_\_  Other - Age \_\_\_\_\_

**Vaccination History:**

HBV / Hep B (Hepatitis B) – Age \_\_\_  MMR (Measles, Mumps, Rubella) – Age \_\_\_  
 DTP or  DTaP (Diphtheria, Tetanus, Pertussis) – Age \_\_\_  Varicella (Chicken Pox) – Age \_\_\_  
 HbCV / Hib (H. influenzae type b conjugate) – Age \_\_\_  PCV (Pneumococcal) – Age \_\_\_  
 OPV (Oral Polio Vaccine) or  IPV (Inactivated Poliovirus) – Age \_\_\_  
Adverse Reactions to Any Vaccine? Y/N List: \_\_\_\_\_

**Insurance**

Do you have medical insurance? Y/N Insurance Company Name \_\_\_\_\_  
Policy Number \_\_\_\_\_ Insurance Company Phone number \_\_\_\_\_  
Insured’s Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Insured’s DOB \_\_\_\_\_ Insured’s SS# \_\_\_\_\_  
Insured’s Employer \_\_\_\_\_ Insured’s Employee Address \_\_\_\_\_

**CONSENT TO CHIROPRACTIC CARE**

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.  
I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_ hereby grant  
permission for my child to receive chiropractic care.

Signed \_\_\_\_\_ Witnessed \_\_\_\_\_

Date \_\_\_\_\_