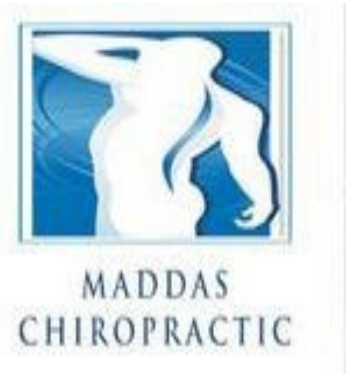

870 McClellandtown Rd., McClellandtown, PA 15458

4313 State Route 51, Rostraver, PA 15012
Phone: (724) 430.4924

FAX: (724) 430.4925

WELCOME!

Pediatric History Form
(Ages 0-10 yrs.)

Patient Name_____ SS#_____

Name of Parents / Guardians_____

Address _____City _____State _____Zip_____

Home Phone_____ Work Phone_____ Email Address_____ Birth Date _____

Sex_____ Weight_____ Height_____

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:

____Dizziness	___Allergies	___Diarrhea	___Broken bones
____ADHD	___Runny Nose	___Poor Appetite	___Sprains/Strains
___ Backaches	___Itchy Eyes	___Hyperactivity	___Hernias
___ Heart Condition	___Rashes	___Behavioral	___Neck Pain
___Chronic Earaches	__ Unusual Moles	___Poor Memory	___Arm/Elbow Pain
___Diabetes	___Neuritis	___Insomnia	___Leg/Hip Pain
___Tuberculosis	___Digestive	___Nightmares	___Knee/Foot Pain
___Hypertension	___Sinus Trouble	___Bed Wetting	___Growing pains
___Fever/Chills	___Cough/Wheeze	___Pain Urinating	___Joint Pain
___Frequent Colds	___Chest Pain	___Convulsions _Paralysis	___Scoliosis
___Arthritis	___Constipation	___Muscle Pain	___Blood disorders
___Headaches	___Anemia	___Fainting	___Stomach Aches
___Asthma	___Rheumatic Fever		___Other

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. influenza type b conjugate) – Age ____ *PCV (Pneumococcal) – Age ____
- PV (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 _____