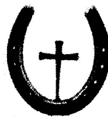
Gates Chiropractic



A Different Approach to Health
for the entire family

PEDIATRIC HISTORY FORM

Dear New Patient,
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. 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.

Date:_________

Patient Name: ____ S.S. #:_________-_________-___________

Address:____ City:________________________________

State:_________ Zip:____________

Age:_______ Birth Date: _____/______ /________ Sex:_____ Weight:__________ Height: ____________

Names of Parents / Guardians: ____

Home Phone:____________________ Work Phone:____________________ Cell Phone:___________________

Referred By:________________________________

Purpose For Contacting Us? ____

____

Referring Physician's Name and Address:____

____

What are the goals that you hope your child will gain?_______________________________________

____

MEDICAL HISTORY:
Check the following conditions that your child has suffered from: (Please elaborate on all marked boxes as appropriate in the space provided)

- ☐ ADD/ADHD
- ☐ Allergies
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Chronic Colds
- ☐ Colic
- ☐ Autism
- ☐ Constipation
- ☐ Diabetes
- ☐ Digestive Problems
- ☐ Depression/ Anxiety
- ☐ Dyslexia
- ☐ Ear Infections
- ☐ Sensory Processing Challenges
- ☐ Fatigue
- ☐ Headaches
- ☐ Hearing Difficulties
- ☐ Heart Problems
- ☐ Kidney Disorders
- ☐ Lymph Disorders
- ☐ Orthopedic Conditions
- ☐ Scoliosis
- ☐ Seizures
- ☐ Sleep Disturbances
- ☐ Torticollis
- ☐ Vision Difficulties
- ☐ Other____

____
____
____
____
____

Current Medications:____

Has your child ever had surgery? ☐ No ☐Yes____

Did you CHOOSE to have your child vaccinated? ☐ No ☐ Yes_______________________________

Has your child had a lot of dental work? ☐ No ☐ Yes If so, what and when?_________________

Does your child wear any orthodontic devices? ☐ No ☐ Yes ________________________________

PRENATAL HISTORY:
Were there any complications or unusual stressors during the pregnancy? ☐ Yes ☐ No ______________

____

Medications during pregnancy? ☐ Yes ☐ NO ____

Cigarette/ Alcohol use during pregnancy? ☐ Yes ☐ No ____________________________________