Pediatric History Form

(For Children 12 Years and Under)

ELDORA FAMILY CHIROPRACTIC & WELLNESS CENTER

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients here at Eldora Family Chiropractic. 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 create better health for your family.

(Please Print)

Patient Name:_____ Name You Prefer Us To Use: _____

Address:_____ City:_____ State:_____

Zip:_____ Home Phone: (_____)_____ Cell: (_____)_____

Date of Birth: _____ Gender: ☐ Female ☐ Male Weight:_____ Height:_____

Parent(s)/Guardian Name(s): _____

Whom may we thank for referring you?:_____

Purpose for Contacting Eldora Family Chiropractic?_____

Have Other Doctors Been Seen for this Condition? ☐ Yes ☐ No If Yes, List Doctor Name(s) and Prior Treatments: _____

_____

Any Other Health Problems?_____

Check Any of the Following Conditions Your Child Has Experienced During the Past Six Months:

☐ Ear Infections	☐ Digestive Problems	☐ Car Accident	☐ Headaches	Additional information on any marked condition:
☐ Asthma / Allergies	☐ Bed Wetting	☐ Chronic Colds	☐ Growing / Back Pains	_____
☐ Colic	☐ Seizures	☐ Recurring Fevers	☐ Autism	_____
☐ Scoliosis	☐ ADD/ADHD	☐ Temper Tantrums	☐ Other:_____	_____

Family History:_____

Previous Chiropractor (If Any):_____Date of Last Visit:_____

Name of Pediatrician:_____Date of Last Visit:_____

Number of **Antibiotics** Your Child has Taken During the Past Six Months: _____ During His/Her Lifetime: _____

Number of Doses of **Other Prescription Medications** Your Child has Taken During the Past Six Months: _____

During His/Her Lifetime: _____ Please List:_____

Vaccination History:_____

Prenatal History:

Name of Obstetrician/Midwife:_____

Complications During Pregnancy: ☐ Yes ☐ No List:_____

Ultrasounds During Pregnancy: ☐ Yes ☐ No Number:_____

Medications During Pregnancy/Delivery: ☐ Yes ☐ No List:_____

Cigarette/Alcohol Use During Pregnancy: ☐ Yes ☐ No

Location of Birth: ☐ Hospital ☐ Birthing Center ☐ Home

Birth Intervention: ☐ Forceps ☐ Vacuum Extraction ☐ Caesarian Section If C-Section: ☐ Emergency ☐ Planned

Complications During Delivery: ☐ Yes ☐ No List:_____

Genetic Disorders or Disabilities: ☐ Yes ☐ No List:_____

Birth Weight:_____ Birth Length:_____ APGAR Scores:_____

Feeding History:

Breast Fed: ☐ Yes ☐ No How Long? _____

Formula Fed: ☐ Yes ☐ No How Long?_____ What Type?_____

Introduced to Solids at _____ Months Introduced to Cows' Milk at _____ Months

Food/Juice Allergies or Sensitivities: ☐ Yes ☐ No List:_____

_____

Developmental History:

During the following developmental stages your child's spine is most vulnerable to stresses and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

Respond to Sound:_____ Respond to Visual Stimuli:_____ Hold Head Up:_____

Sit Up:_____ Cross Crawl:_____ Stand Alone:_____ Walk Alone:_____

According to the National Safety Council, approximately 50% of children fall head-first from a high place during their first year of life (for example: a bed, changing table, stairs, etc.). Has your child had a head-first fall? ☐ Yes ☐ No

Is/has your child been involved in any high impact or contact sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)?

☐ Yes ☐ No List:_____

Has Your Child Ever Been Involved in a Car Accident? ☐ Yes ☐ No List:_____

Has Your Child Been Seen on an Emergency Basis? ☐ Yes ☐ No List:_____

Other Traumas Not Described Above? ☐ Yes ☐ No List:_____

Prior Surgery: ☐ Yes ☐ No List:_____

Menarche: ☐ Yes ☐ No Age:_____

Childhood Diseases: Please mark all that apply.

☐ Chicken Pox Age:_____ ☐ Mumps Age:_____

☐ Rubella Age:_____ ☐ Whooping Cough Age:_____

☐ Rubeola Age:_____ ☐ Other(s) List:_____

We are here to serve you and we encourage you to ask questions. Your participation is vital and will help determine your child's results.

Authorization for Care of Minor

I hereby authorize **Eldora Family Chiropractic**, its Doctors and Staff to administer Chiropractic care to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees at the time services are rendered unless other prior arrangements have been made.

Name of Parent/Guardian:_____ Date: _____

Signature of Parent/Guardian:_____

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