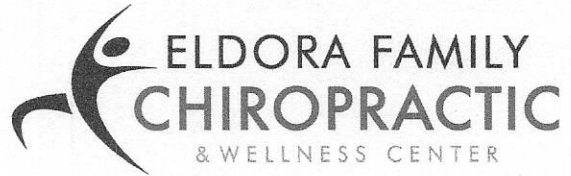


# Pediatric History Form

(For Children 12 Years and Under)



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:

- |   |   |   |   |   |
|---|---|---|---|---|
| <input type="checkbox"/> Ear Infections     | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Car Accident     | <input type="checkbox"/> Headaches            | Additional information on any marked condition:<br>_____<br>_____ |
| <input type="checkbox"/> Asthma / Allergies | <input type="checkbox"/> Bed Wetting        | <input type="checkbox"/> Chronic Colds    | <input type="checkbox"/> Growing / Back Pains |   |
| <input type="checkbox"/> Colic              | <input type="checkbox"/> Seizures           | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Autism               |   |
| <input type="checkbox"/> Scoliosis          | <input type="checkbox"/> ADD/ADHD           | <input type="checkbox"/> Temper Tantrums  | <input type="checkbox"/> 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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