PEDIATRIC HISTORY FORM

Dear New Patient,

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.

Patient Name: _____ S.S.#: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Birth Date: _____/_____/_____ Sex: ❑ Male ❑ Female Weight: _____ Height: _____

Name of Parents / Guardians: _____ Work Phone: _____

Referred By: _____

Purpose for contacting us? _____

Other Doctors seen for this condition: ❑ No ❑ Yes If yes, Doctors' names and Prior Treatments: _____

_____

Other Health Problems? _____

Check any of the following conditions your child has suffered from during the past six months:

❑ Ear Infections	❑ Scoliosis	❑ Seizures	❑ Chronic Colds	❑ Headaches
❑ Asthma / Allergies	❑ Digestive Problems	❑ ADHD	❑ Recurring Fevers	❑ Growing / Back Pains
❑ Colic	❑ Bed Wetting	❑ Car Accident	❑ Temper Tantrums	❑ Other:_____

Family History: _____

Previous Chiropractic care: ❑ No ❑ Yes Chiropractor name: _____

Date of last visit: _____/_____/_____ Reason: _____

Name of Pediatrician: _____

Date of last visit: _____/_____/_____ Reason: _____

Are you satisfied with the care your child has received there? ❑ No ❑ Yes

Number of doses of **Antibiotics** your child has taken:

During the past Six Months: _____ Total during his/her lifetime: _____

Number of doses of **Other Prescription Medications** your child has taken:

During the past Six Months: _____ Total during his/her lifetime: _____ List: _____

Vaccination History: _____

Prenatal History:

Name of Obstetrician / Midwife: _____

Complications during pregnancy? ❑ No ❑ Yes List: _____

Ultrasounds during pregnancy? ❑ No ❑ Yes Number: _____

Medications during pregnancy / delivery? ❑ No ❑ Yes List: _____

Cigarette / Alcohol use during pregnancy? ❑ No ❑ Yes

Location of birth: ❑ Hospital ❑ Birthing Center ❑ Home