

**Pediatric Patient Information**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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 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: \_\_\_\_\_ Name of Parents/Guardian: \_\_\_\_\_  
Email: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Guardian Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ SS#: \_\_\_\_\_  
Age: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

**How did you hear about our office or Whom may we thank for referring you to us?** \_\_\_\_\_

**Purpose for this appointment?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Doctors seen for this condition: Y N  
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/ADD     | Recurring Fevers | Growing/Back Pains | Colic     | Bedwetting       |
| Temper Tantrums    | Others _____ |                  |                    |           |                  |

Family History: \_\_\_\_\_

Previous **Chiropractor**: \_\_\_\_\_ Date of last visit: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Reason: \_\_\_\_\_

Name of **Pediatrician**: \_\_\_\_\_ Date of Last Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Reason: \_\_\_\_\_

**Past Surgeries:** Y N List: \_\_\_\_\_

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: \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

Vitamins/ Herbs: \_\_\_\_\_

Vaccination History: \_\_\_\_\_

Allergic To: \_\_\_\_\_

**Prenatal and Birth History:**

Name of Obstetrician/ Midwife: \_\_\_\_\_

Complications During Pregnancy? Y N List: \_\_\_\_\_

Ultrasounds During Pregnancy? Y N Number: \_\_\_\_\_

Medications During Pregnancy / Delivery? Y N List: \_\_\_\_\_

Cigarette/ Alcohol Use During Pregnancy: Y N

Location of Birth: Hospital Birthing Center Home

Birthing Intervention: Medication Epidural Forceps Vacuum Emergency C-Section Planned C-Section

Complications During Delivery? Y N List: \_\_\_\_\_

Breech Presentation: Y N

Genetic Disorders or Disabilities: Y N List: \_\_\_\_\_

Was there present at birth \_\_\_Jaundice \_\_\_Cyanosis

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ APGAR Score: \_\_\_\_\_

**Feeding History:**

Breast Fed: Y N How Long: \_\_\_\_\_

Formula Fed: Y N How Long: \_\_\_\_\_ Type: \_\_\_\_\_

Introduced to Solids at: \_\_\_\_\_ months Cow's milk at \_\_\_\_\_ months

Food/ Juice Allergies or Intolerances: Y N List: \_\_\_\_\_

**Developmental History:**

During different developing milestones (hold head up, sit up, crawl, stand, walk) your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.).

Was this the case with your child? Y N

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

Has Your Child Ever Been Involved in a Car Accident? Y N List: \_\_\_\_\_

Has Your Child Been Seen on an Emergency Basis? Y N List: \_\_\_\_\_

Other Traumas Not Described Above? Y N List: \_\_\_\_\_

Childhood Diseases:

Chicken Pox	Y	N	Age _____	Mumps	Y	N	Age _____
Rubella	Y	N	Age _____	Whooping Cough	Y	N	Age _____
Measles	Y	N	Age _____	Other	Y	N	Age _____