

### Pediatric History Form

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Appointment Date \_\_\_\_\_

Name of Parents / Guardians \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email address \_\_\_\_\_

Sex \_\_\_\_\_ Current Weight \_\_\_\_\_ Current Height \_\_\_\_\_ Number of siblings \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

Reason for seeking chiropractic care: \_\_\_\_\_

Other Doctors seen for this condition Y/N Specialty: \_\_\_\_\_

Prior treatment and outcome: \_\_\_\_\_

Other Health Problems: \_\_\_\_\_

**Symptoms:** Please check any current or past problems your child has on the list below:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Dizziness        | <input type="checkbox"/> Allergies       | <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Broken bones    |
| <input type="checkbox"/> ADHD             | <input type="checkbox"/> Runny Nose      | <input type="checkbox"/> Poor Appetite  | <input type="checkbox"/> Sprains/Strains |
| <input type="checkbox"/> Backaches        | <input type="checkbox"/> Itchy Eyes      | <input type="checkbox"/> Hyperactivity  | <input type="checkbox"/> Hernias         |
| <input type="checkbox"/> Heart Condition  | <input type="checkbox"/> Rashes          | <input type="checkbox"/> Behavioral     | <input type="checkbox"/> Neck Pain       |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Unusual Moles   | <input type="checkbox"/> Poor Memory    | <input type="checkbox"/> Arm/Elbow Pain  |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Neuritis        | <input type="checkbox"/> Insomnia       | <input type="checkbox"/> Leg/Hip Pain    |
| <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> Digestive       | <input type="checkbox"/> Nightmares     | <input type="checkbox"/> Knee/Foot Pain  |
| <input type="checkbox"/> Hypertension     | <input type="checkbox"/> Sinus Trouble   | <input type="checkbox"/> Bed Wetting    | <input type="checkbox"/> Growing pains   |
| <input type="checkbox"/> Fever/Chills     | <input type="checkbox"/> Cough/Wheeze    | <input type="checkbox"/> Pain Urinating | <input type="checkbox"/> Joint Pain      |
| <input type="checkbox"/> Frequent Colds   | <input type="checkbox"/> Chest Pain      | <input type="checkbox"/> Convulsions    | <input type="checkbox"/> Scoliosis       |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Constipation    | <input type="checkbox"/> Paralysis      | <input type="checkbox"/> Blood disorders |
| <input type="checkbox"/> Headaches        | <input type="checkbox"/> Anemia          | <input type="checkbox"/> Muscle Pain    | <input type="checkbox"/> Stomach Aches   |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Fainting       | <input type="checkbox"/> Other           |

**Health History:**

Name of Pediatrician: \_\_\_\_\_ Date of last visit \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Medications and conditions being treated: \_\_\_\_\_

Has your child ever taken antibiotics? Y/N Condition treated: \_\_\_\_\_

Has your child been injured participating in contact sports (Soccer, Football, Martial Arts...) Y/N

If yes, describe (Sprain, Broken Bone, Head Trauma...) \_\_\_\_\_

Has your child ever been involved in a car accident? Y/N Date & Injuries \_\_\_\_\_

Has your child ever fallen head first from (Changing Table, Bed, Stairs...) Y/N \_\_\_\_\_

Other traumas not described above? Y/N Type & Date: \_\_\_\_\_

Prior surgery: Y/N Type and Date: \_\_\_\_\_ Menarche: Y/N Age: \_\_\_\_\_

**Prenatal History**

Complications during pregnancy: Y/N List: \_\_\_\_\_

Birth intervention:  Forceps  Vacuum  Caesarian, Why? \_\_\_\_\_

Complications during delivery: Y/N List: \_\_\_\_\_

Genetic disorders or disabilities: Y/N List: \_\_\_\_\_

Birth weight \_\_\_\_\_ Birth length \_\_\_\_\_ APGAR scores: 1 min \_\_\_\_\_ 5 min \_\_\_\_\_

**Feeding history**

Breast Fed: Y/N How long? \_\_\_\_\_ Formula fed: Y/N How long? \_\_\_\_\_

Food / juice allergies or intolerances Y/N List: \_\_\_\_\_

**Developmental History**

Sleep (Hrs per night) \_\_\_\_\_ Naps (number & lengths) \_\_\_\_\_ Problems sleeping \_\_\_\_\_

At what age was your child able to: Crawl \_\_\_ Sit alone \_\_\_ Stand alone \_\_\_ Walk alone \_\_\_ Say words \_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_