



PEDIATRIC HISTORY FORM

PATIENT NAME: _____ NICKNAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SSN: _____ BIRTHDAY: _____ AGE: _____ MALE FEMALE

NAME OF PARENTS/GUARDIANS: _____

HOME PHONE: _____ CELL PHONE: _____

HOW DID YOU FIRST HEAR OF CORRECTIVE CHIROPRACTIC?

PARENT IS A PATIENT TV NEWSPAPER BILLBOARD FRIEND OTHER: _____

PURPOSE FOR CONTACTING US? _____

OTHER DOCTORS SEEN FOR THIS CONDITION? YES NO IF YES, PLEASE LIST DOCTORS AND TREATMENTS:

1. _____
2. _____
3. _____

REGARDING CONDITION:

IS IT RELATED TO AN AUTOMOBILE ACCIDENT? NO YES

HOW DID THIS HAPPEN? _____

WHEN DID THE SYMPTOMS FIRST START? _____

HOW FREQUENT ARE THE SYMPTOMS? _____

DESCRIBE THE SYMPTOMS: _____

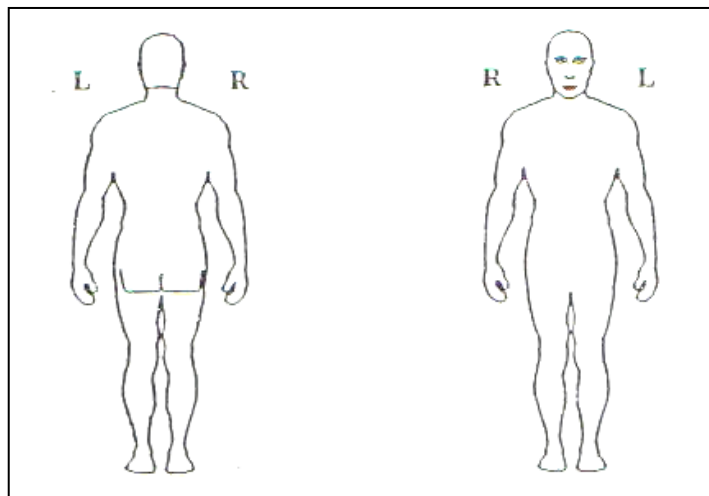
WHAT MAKES IT WORSE? _____

WHAT MAKES IT BETTER? _____

DOES IT RADIATE TO ANY OTHER PARTS OF THE BODY? _____

HAS THIS CHANGED ACTIVITIES AT HOME? _____

Please mark all the areas of complaint on the diagrams below.



PRENATAL HISTORY:

MOM'S HEALTH DURING PREGNANCY: _____

COMPLICATIONS DURING PREGNANCY: NO YES ; PLEASE LIST: _____

MEDICATIONS DURING DELIVERY: INDUCTION YES NO EPIDURAL YES NO OTHER: _____

BIRTH INTERVENTION: FORCEPS VACUUM EXTRACTION CAESARIAN – EMERGENCY / PLANNED?

COMPLICATIONS DURING DELIVERY: NO YES ; PLEASE LIST: _____

DELIVERY: < 36 WEEKS 37 – 42 WEEKS > 42 WEEKS

BIRTH WEIGHT: _____ LENGTH _____

FEEDING HISTORY:

BREAST FED: YES NO ; HOW LONG? _____

FORMULA FED: YES NO ; HOW LONG? _____

INTRODUCED TO SOLIDS AT: _____ MONTHS; COW'S MILK AT _____ MONTHS

FOOD / JUICE ALLERGIES OR INTOLERANCES NO YES; PLEASE LIST: _____

HEALTH HISTORY:

CHECK ANY OF THE FOLLOWING CONDITIONS YOUR CHILD HAS SUFFERED FROM DURING THE LAST 6 MONTHS:

- | | | |
|---|---|--|
| <input type="checkbox"/> EAR INFECTIONS | <input type="checkbox"/> SEIZURES | <input type="checkbox"/> GROWING PAINS |
| <input type="checkbox"/> ASTHMA/ALLERGIES | <input type="checkbox"/> ADHD | <input type="checkbox"/> NECK PAIN |
| <input type="checkbox"/> COLIC | <input type="checkbox"/> CAR ACCIDENT | <input type="checkbox"/> BACK PAIN |
| <input type="checkbox"/> SCOLIOSIS | <input type="checkbox"/> CHRONIC COLDS | <input type="checkbox"/> SLEEPLESSNESS |
| <input type="checkbox"/> DIGESTIVE PROBLEMS | <input type="checkbox"/> RECURRING FEVERS | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> BED WETTING | <input type="checkbox"/> HEADACHES | |

HAS YOUR CHILD EVER BEEN HOSPITALIZED? YES NO IF YES, WHY? _____

HAS YOUR CHILD HAD ANY SIGNIFICANT INJURIES? _____

IS YOUR CHILD ON ANY MEDICATIONS? _____

HAS YOUR CHILD TAKEN ANY ANTIBIOTICS? NO YES;

IF YES, HOW MANY DOSES IN THE LAST 6 MO? _____ TOTAL DURING HIS/HER LIFETIME: _____

HAS YOUR CHILD BEEN VACCINATED? NO YES; WHEN: _____

ANY CHILDHOOD DISEASES?

- | | | |
|--------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> WHOOPING COUGH | <input type="checkbox"/> RSV |
| <input type="checkbox"/> RUBELLA | <input type="checkbox"/> MUMPS | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> MEASLES | <input type="checkbox"/> PERTUSSES | |

DOES YOUR CHILD TAKE A MULTIVITAMIN OR ANY OTHER NUTRITIONAL SUPPLEMENTS? _____

HOW MANY SERVINGS OF FRUITS AND VEGETABLES DOES YOUR CHILD EAT ON A DAILY BASIS: _____

HOW MANY SODAS (12 OZ) DOES YOUR CHILD DRINK PER DAY? _____ HOW MUCH WATER (IN OUNCES) PER DAY? _____

WHAT POSITION DOES YOUR CHILD SLEEP IN? BACK SIDE STOMACH HOW MANY PILLOWS DOES HE/SHE USE? _____

DAILY ACTIVITIES/SPORTS

IS YOUR CHILD INVOLVED IN ANY HIGH IMPACT OR CONTACT TYPE SPORTS? (I.E. SOCCER, FOOTBALL, GYMNASTICS, BASEBALL,

CHEERLEADING, MARTIAL ARTS, ETC) _____

PLEASE LIST ANY INJURIES AS A RESULT OF THEIR ACTIVITIES: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____