Broadneck Family Chiropractic

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Pediatric History Form

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 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: _____ Address: _____

City, State: _____ Zip: _____ Home Phone: _____

Birth date: ___/___/___ Gender: _____ Weight: _____ Height: _____

Names of Parents / Guardians: _____

Referred by: _____ Purpose For Contacting Us? _____

Other doctors seen for this condition? __ N __Y , Doctors' Names and Prior Treatment: _____

_____

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 Accidents
- ☐ Temper Tantrums
- ☐ Issues Breastfeeding
- ☐ Other _____

Family History _____

Previous Chiropractor: _____ Date of last visit __/__/__Reason: _____

Name of Pediatrician: _____ Date of last visit __/__/__Reason: _____

Are you satisfied with the care your child received there? _____ N _____ Y

Number of Doses of Antibiotics your child has taken: During the past six months: ____, Total during their lifetime: ____

Number of Doses of Other prescription medications your child has taken:

During the past six months: _____, Total during his /her lifetime: _____ Name: _____

Vaccination History: _____

Prenatal History:

Name of Obstetrician / Midwife: _____

Complications during pregnancy? _____ N _____ Y List: _____

Ultrasounds during pregnancy? _____ N _____ Y, Number: _____

Medications during pregnancy / Delivery? _____ N _____ Y List: _____

Cigarette / Alcohol use during pregnancy: _____ N _____ Y

Location of birth: Hospital _____ Birthing Center _____ Home _____

Delivery Conditions: _____ Forceps _____ Vacuum Extraction _____Caesarean Section (Emergency or Planned?)

Complications during delivery? ___ N ___ Y List: _____

Genetic disorders or disabilities? ___ N ___ Y List: _____

Birth weight: _____ Birth length: _____ APGAR Scores: _____, _____

Feeding History:

Breast Fed: ___ N ___ Y, How long: _____ Formula Fed: ___ N ___ Y, How long: _____Type: _____

Introduced to solids at: _____ months Cow's milk at _____ months

Food / Juice Allergies or Intolerance: _____ N _____ Y, List: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should be routinely 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 (i.e., a bed, changing table, down stairs, etc.) Was this the case with your child? _____ N _____ Y

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

Has your child ever been involved in a car accident? _____ N _____ Y List: _____

Has your child ever been seen on an emergency basis? _____ N _____ Y List: _____

Other traumas not described above? _____ N _____ Y List: _____

Prior Surgery: _____ N _____ Y, List: _____

Menarche: _____ N _____ Y, Age: ____

Childhood Diseases:

Chicken Pox N / Y, Age ___
Whooping Cough N / Y, Age ___
Mumps N / Y, Age ___
Rubeola N / Y, Age ___
Rubella N / Y, Age ___
Other N / Y, Age ___

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.
Name of Insurance Company: _____ Policy#: _____

Signed: _____ Witnessed: _____ Date: _____ / _____ / _____