PEDIATRIC HEALTH HISTORY FORM

Name: _____ Date: _____

Sex: _____ Birth Date: _____ Age: _____ Social Security #: _____

Address: _____ _____ _____ _____

Residence and Mailing City State Zip Code

Parent/Guardian Name: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____ Email: _____

How did you hear about us? _____ Billboard _____ Referral (Please Name) _____

_____ Radio _____ Magazine Ad (Please List) _____

_____ Internet _____ Other (Please List) _____

Primary Complaint and Location

Purpose for Contacting Us? _____

Other Doctors Seen for this Condition?: Y N Doctors' Names and Treatments:_____

_____

Other Health Problems? _____

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

❒ Ear infections ❒ Scoliosis ❒ Seizures ❒ Growing/Back pains ❒ Headaches

❒ Digestive problems ❒ ADHD ❒ Recurring fevers ❒ Chronic colds ❒ Asthma/Allergies

❒ Bed wetting ❒ Colic ❒ Car accident ❒ Temper tantrums

Other _____

Health History

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 receives there? Y N

Number of doses of antibiotics your child has taken: During the past six (6) months: _____ Lifetime: _____

List the antibiotics taken: _____

Vaccination History: _____

Prenatal History

Name of Obstetrician / Midwife: _____

Complications during pregnancy? Y N , _____

Ultrasounds during pregnancy? Y N , Number: _____

Medications during pregnancy / delivery? Y N , List: _____

Cigarette / Alcohol use during pregnancy? Y N , Amount: _____

Location of birth: ❒ Hospital ❒ Birthing Center ❒ Home

Birth intervention: ❒ Forceps ❒ Vacuum extraction ❒ Caesarian section ❒ Emergency or ❒ Planned

Complications during delivery? Y N , List: _____

Genetic disorders or disabilities? Y N , List: _____

Birth weight: _____ Birth length: _____ APGAR scores: _____ , _____

Feeding History

Breast fed: Y N , How long: _____

Formula fed: Y N , How long: _____ Type: _____

Introduced to solid foods at: _____ Months, Cows milk at: _____ Months

Food / Juice allergies or intolerances: Y N , List: _____

Developmental History

At what age was your child able to:

_____ Respond to stimuli (sounds and touching) _____ 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? Y N

Is / Has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? Y N , List: _____

Has your child ever been 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: _____ Rubella Y N Age: _____ Rubeola Y N Age: _____

Mumps Y N Age: _____ Whooping Cough Y N Age: _____ Other Y N Age: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

_____ _____

Signature (Patient or Guardian) *Date*

*****Do Not Write Below This Line*****

Infant Reflexes – Under 1	**RT**	**LT**	***Palpation Exam***								
Rooting	P A	P A	OCC	C1	C2	C3	C4	C5	C6	C7	
Sucking	P A	P A									
Nasopharyngeal	P A	P A									
Blink	P A	P A	T1	T2	T3	T4	T5	T6	T7	T8	T9
Pupillary	P A	P A									
Head Control	P A	P A									
Tonic Neck	P A	P A	T10	T11	T12		L1	L2	L3	L4	L5
Neck Righting	P A	P A									
Otolith Righting	P A	P A	SAC	LI	RI	Doctor's Notes:					
Palmar Grasp	P A	P A									

P = Present A = Absent