

# Pediatric Health History

Name \_\_\_\_\_ Parent(s) Name \_\_\_\_\_

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

Date \_\_\_\_\_ Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ (Age \_\_\_\_\_)

**Purpose for Contacting Us?** \_\_\_\_\_

Other Health Problems? \_\_\_\_\_

Check any of the Following Conditions Your Child has Suffered from During the Past Six Months:

- |   |   |                                       |   |                                     |
|---|---|---------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Ear Infections   | <input type="checkbox"/> Scoliosis          | <input type="checkbox"/> Seizures     | <input type="checkbox"/> Chronic Colds    | <input type="checkbox"/> Headaches  |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD         | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Back Pain  |
| <input type="checkbox"/> Colic            | <input type="checkbox"/> Bed Wetting        | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Temper Tantrums  | <input type="checkbox"/> Other_____ |

Previous Chiropractor \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Birth Intervention? \_\_\_\_\_ Forceps \_\_\_\_\_ Vacuum Extraction \_\_\_\_\_ C-Section

Complications During Delivery? \_\_\_\_\_ N \_\_\_\_\_ Y Describe \_\_\_\_\_

Number of Doses of Antibiotics Your Child has Taken \_\_\_\_\_ What For? \_\_\_\_\_

Number of Doses of Other Prescription Medications Your Child has Taken \_\_\_\_\_ List \_\_\_\_\_

Vaccinations (if any) \_\_\_\_\_

Breast Fed or Bottle Fed? (Circle One) Any Difficulties Feeding on One Side? \_\_\_\_\_

Sleeping Patterns \_\_\_\_\_

Please Describe Any of the Following that have Occurred:

Falls onto the Head, Body or Buttocks

Car Accidents/Sporting Injuries/Other Traumas

I have accurately completed the necessary information, thoroughly read and understand the Terms of Acceptance, and give full consent to the Doctor to administer care to my Son/Daughter as they deem necessary.

\_\_\_\_\_ (Signature) \_\_\_\_\_ (Date)