

## Confidential Pediatric History Form

It is our 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 better serve you, please complete the following information. We look forward to working with you!  
Thank You!

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Date: \_\_\_\_\_ Referred By: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Do you have other immediate household family members who are patients here? Y N

If yes, please list them \_\_\_\_\_

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

Sex: M F Weight: \_\_\_\_\_ Height: \_\_\_\_\_ S.S.#: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Name of Parents/Guardians: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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

Other Doctors seen for this condition: Y N If yes, please list doctor's name and prior treatments: \_\_\_\_\_

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

Ear infections	Bed Wetting	Recurring Fevers	Other:
Asthma/Allergies	Seizures	Temper Tantrums	_____
Colic	ADHD	Headaches	_____
Scoliosis	Auto Accident	Growing/Back Pains	_____
Digestive Problems	Chronic Colds		

Family History: \_\_\_\_\_

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

Were you satisfied? Y N Why? \_\_\_\_\_

Previous / Current Pediatrician: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_ Reason: \_\_\_\_\_

Number of doses of antibiotics your child has taken:

a) During the past six months: \_\_\_\_\_

b) Total during his/her life: \_\_\_\_\_

Number of doses of other prescription medications your child has taken:

c) During the past six months: \_\_\_\_\_

d) Total during his/her life: \_\_\_\_\_

Vaccination History: \_\_\_\_\_

**Feeding History**

Breast Fed: Y N If yes, how long? \_\_\_\_\_ Formula: Y N If yes, how long: \_\_\_\_\_

Introduced to solids at \_\_\_\_\_ months. Cow's milk at \_\_\_\_\_ months. Food/juice allergies or tolerances: Y N

If Yes, please list: \_\_\_\_\_ Other allergies or tolerances: Y N If Yes, please list: \_\_\_\_\_

Number of Hours Sleeping per Night: \_\_\_\_\_ Quality of Sleep: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

**Prenatal History:**

Name of obstetrician/midwife: \_\_\_\_\_ Pediatrician / Family MD: \_\_\_\_\_

Birth intervention: Forceps \_\_\_\_\_ Vacuum Extraction: \_\_\_\_\_ Caesarian Section: \_\_\_\_\_ Emergency or Planned?: \_\_\_\_\_

Ultrasounds during pregnancy? Y N If yes, how many: \_\_\_\_\_

Medications during pregnancy/delivery? Y N If Yes, please list them: \_\_\_\_\_

Cigarette/alcohol use during pregnancy? Y N

**Childhood Diseases:**

Chicken Pox: Y N Age: \_\_\_\_\_ Rubella: Y N Age: \_\_\_\_\_ Whooping Cough: Y N Age: \_\_\_\_\_

Rubella: Y N Age: \_\_\_\_\_ Mumps: Y N Age: \_\_\_\_\_ Other: \_\_\_\_\_

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 – If yes, please explain: \_\_\_\_\_

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 If Yes, Please list: \_\_\_\_\_

Has your child ever been involved in a car accident? Y N If yes, please explain: \_\_\_\_\_

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.

YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

I hereby authorize **The Wellness Way – Bloomington** 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.

Signed: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_