In Touch Chiropractic PLLC

Pediatric History Form
Patient Name_____
Name of Parents / Guardians_____
Address _____City _____

State _____Zip_____
Home Phone_____ Work Phone_____
Birth Date _____ Sex_____ Weight_____ Height_____ Number of siblings_____
Who referred you to us? _____
Reason for seeking chiropractic care**:**_____
Other Doctors seen for this condition Y/N Specialty: _____
Prior treatment and outcome: _____
Other Health Problems: _____
Symptoms: Please check any current or past problems your child has on the list below:

_Dizziness
_ADHD
_Backaches
_Heart Condition
_Chronic Earaches
_Diabetes
_Tuberculosis
_Hypertension
_Fever/Chills
_Frequent Colds
_Arthritis
_Headaches
_Asthma
_Allergies

_Runny Nose
_Itchy Eyes
_Rashes
_Unusual Moles
_Neuritis
_Digestive
_Sinus Trouble
_Cough/Wheeze
_Chest Pain
_Constipation
_Anemia
_Rheumatic Fever

_Diarrhea
_Poor Appetite
_Hyperactivity
_Behavioral
_Poor Memory
_Insomnia
_Nightmares
_Bed Wetting
_Pain Urinating
_Convulsions
_Paralysis
_Muscle Pain
_Fainting

_Broken bones
_Sprains/Strains
_Hernias
_Neck Pain
_Arm/Elbow Pain
_Leg/Hip Pain
_Knee/Foot Pain
_Growing pains
_Joint Pain
_Scoliosis
_Blood disorders
_Stomach Aches
_Other

Health History:
Name of Pediatrician: _____ Date of last visit ____
Reason for visit:
_____
Medications and conditions being treated:
_____
Has your child ever taken antibiotics? Y/N Condition treated:
_____
Has your child been injured participating in contact sports (Soccer, Football, Martial Arts…) Y/N

If yes, describe (Sprain, Broken Bone, Head Trauma…)

_____

Has your child ever been involved in a car accident? Y/N Date & Injuries

_____

Has your child ever fallen head first from (Changing Table, Bed, Stairs…) Y/N

_____

Other traumas not described above? Y/N Type & Date:

_____

Prior surgery: Y/N Type and Date:_____ Menarche: Y/N Age:_____

Prenatal History

Location of Birth: O Home O Birthing Center O Hospital O Stepchild O Adopted

Complications during pregnancy: Y/N List:

_____

Ultrasounds during pregnancy: N Y Number: _____

Medications during pregnancy/delivery: Y/N List:

_____

Cigarette / Alcohol use during pregnancy: Y/N

Birth intervention: O Forceps O Vacuum O Caesarian, Why?

_____

Complications during delivery: Y/N List:

_____

Genetic disorders or disabilities: Y/N List:

_____

Birth weight_____ Birth length_____ APGAR scores: 1 min _____ 5 min _____

Feeding history

Breast Fed: Y/N How long'?_____ Formula fed: Y/N How long'?_____

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

Food / juice allergies or intolerances Y/N List: _____

Developmental History

Sleep (Hrs per night) _____ Naps (number & lengths) _____ Problems sleeping

_____

At hat age was your child able to: Crawl __ Sit alone __ Stand alone __ Walk alone __ Say words __

Childhood Diseases

O Chicken Pox - Age ___ O Mumps - Age ___ O Rubella - Age ___ O Whooping cough - Age ___

O Measles - Age ___ O Meningitis - Age ___ O Tuberculosis - Age ___ O Other - Age _____

Vaccination History:

Adverse Reactions to Any Vaccine? Y/N List: _____

CONSENT TO CHIROPRACTIC CARE

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.
I, _____, being the parent or legal guardian of
_____ hereby grant permission for my child to receive chiropractic care.

Signed _____Witnessed
_____

Date _____