Pediatric History Form (Birth to 12 years old)

First Name _____ MI ____ Last Name _____

Home Address _____ City/State/Zip _____

Home Phone _____ Mobile Phone _____

Email Address _____

Date of Birth _____ Social Security Number _____

Height _____ Weight _____ Sex: M F

Emergency Contact Name and Phone Number _____

Have you ever been to a Chiropractor before? Yes No
If so, who? _____

Medical History
Please list conditions you have been treated for in the last 10 years:

_____

_____

_____

_____

Please list all surgeries and operations:

_____

_____

_____

_____

Please list all current medications/dosages:

_____

_____

_____

_____

Please list all nutritional supplementation (please also include vitamins, minerals, and herbs):

_____

_____

_____

_____

Did you breastfeed your child? Yes No
When did she start nursing for the first time? _____
Any issues with latching right away? _____
Does your child prefer one breast over the other? Yes No
If yes, which side? Right Left Has your child been immunized? Yes No
Did your child have any negative reaction to the vaccinations? Yes No
If yes, please describe_____ Were they reported? Yes No

Baby / Toddler (age 0-4)
Have any of the following occurred? (please circle)

Fall from changing table	Frequent crying spells	Tumble down stairs
Car accident	Fall out of crib	Fall on playground
Frequent ear infections	Tonsillitis	Frequent fevers
Frequent diarrhea	Constipation	Colic
Sleeping problems	Frequent colds	Weight gain / loss

Other: _____

Child (age 5-12)
Have any of the following occurred? (please circle)

Fall from a tree	Fall off a bicycle	Sports accident
Car accident	Stomach pains	Scoliosis
Bed wetting	Fall on playground	Hyperactivity
Autism	Asthma	Allergies
Leg / knee pains	Growing pains	Other:_____

Prenatal History
Is your child adopted? Yes No
Did you have any pregnancy-related complications? Yes No
If yes, please describe _____

Place of birth: Home Birthing Center Hospital
Provider: Midwife OB-GYN Other: _____
Type of Birth: Vaginal C-section

What interventions were performs?
C-section Yes No

Pitocin Yes No
Epidural Yes No
Strep B test Yes No
Water broken by provider Yes No
Membranes stripped Yes No
Care provider assistance? Yes No
Did anyone help the baby come out? Yes No
Forceps Yes No Vacuum Extraction Yes No
What position did you deliver in? Squatting On Back Water birth
Other: _____

Was labor assisted by: Doctor pulling Vacuum Forceps None
How long was 1st stage labor (contractions)? _____ How long was second stage labor (pushing)?_____
Did you baby receive the following at the hospital after birth?
Hep B? Yes No
Vitamin K shot? Yes No
Ointment to eyes? Yes No
Did your child have a misshapen skull or head? Yes No
Were there purple markings on their face? Yes No

Daily Habits and Activities
Does your child participate in any of the following (please circle) Soccer Football Gymnastics Karate Hockey Lacrosse Basketball Wrestling Baseball Softball Volleyball Tennis Dance Swimming Other Sport: _____
How would you rate your child's diet? Well balanced Average High sugar / processed foods
Does your child consume artificial sweeteners? Yes No Does your child drink water? Yes No
Any concerns with bowel movements or stomach issues? _____

Has she been on antibiotics before? _____
Number of hours your child sleeps? Hours per day _____
Sleep quality? Good Fair Poor

Parent Questions or Comments for Doctor:
_____
_____
_____
_____
_____
_____
_____