

**Children's History Form**

Patient Name \_\_\_\_\_

Date of Birth: \_\_\_\_\_

S.S.# \_\_\_\_\_

Parent's Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Sex: M / F    Weight: \_\_\_\_\_ Height: \_\_\_\_\_

City: \_\_\_\_\_

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

State \_\_\_\_\_ Zip: \_\_\_\_\_

Names of Parents/Guardians: \_\_\_\_\_

Home Phone: \_\_\_\_\_

\_\_\_\_\_

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

Other Doctors Seen for this Condition Y / N    Doctors' Names and Prior Treatments: \_\_\_\_\_

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"/> Bed Wetting   | <input type="checkbox"/> Recurring Fevers   |
| <input type="checkbox"/> Asthma/Allergies   | <input type="checkbox"/> Seizures      | <input type="checkbox"/> Temper Tantrums    |
| <input type="checkbox"/> Colic              | <input type="checkbox"/> ADHD          | <input type="checkbox"/> Headaches          |
| <input type="checkbox"/> Scoliosis          | <input type="checkbox"/> Car Accident  | <input type="checkbox"/> Growing/Back Pains |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Other _____        |

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

Do you or anyone in your household smoke? N / Y    If yes, inside or outside of the home? (circle one)

Previous Chiropractor: \_\_\_\_\_

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

Name of Pediatrician: \_\_\_\_\_

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

Are You Satisfied with the Care Your Child has Received There? Y / N

Number of Doses of Antibiotics Your Child has Taken:

During the Past Six Months: \_\_\_\_\_, Total During His/Her Lifetime: \_\_\_\_\_

Number of Doses of Other Prescription Medications Your Child has Taken:

During the Past Six Months: \_\_\_\_\_, Total During His/Her Lifetime: \_\_\_\_\_ List: \_\_\_\_\_

\_\_\_\_\_

What Over the Counter Medications Does Your Child Ever Take? \_\_\_\_\_

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

Does your child take any supplements/vitamins? N / Y List: \_\_\_\_\_

Prenatal History:

Name of Obstetrician / Midwife: \_\_\_\_\_

Complications During Pregnancy? N / Y, List: \_\_\_\_\_

Was your Child Breech? N / Y

Ultrasounds During Pregnancy? N / Y, Number \_\_\_\_\_

Medications During Pregnancy/Delivery? N / Y, List: \_\_\_\_\_

Cigarette/Alcohol Use During Pregnancy: N / Y

Location of Birth: Hospital / Birthing Center / Home

Birth Intervention: Forceps / Vacuum Extraction / Caesarian Section (Emergency or Planned?)

Complications During Delivery? N / Y, List: \_\_\_\_\_

Genetic Disorders or Disabilities: N / Y, List: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ APGAR scores: \_\_\_\_\_

Feeding History:

Breast Fed: N / Y, How Long \_\_\_\_\_

Formula Fed: N / Y, How Long \_\_\_\_\_ Type: \_\_\_\_\_

Introduced to Solids at : \_\_\_\_\_ Months Cows Milk: \_\_\_\_\_ Months

Food/Juice Allergies or Intolerances: N / Y, List: \_\_\_\_\_

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

\_\_\_\_\_ Respond to Sound

\_\_\_\_\_ Cross Crawl

\_\_\_\_\_ Respond to Visual Stimuli

\_\_\_\_\_ Stand Alone

\_\_\_\_\_ Hold Head Up

\_\_\_\_\_ Walk Alone

\_\_\_\_\_ Sit Up

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first ear of life (i.e., a bed, changing table, down stairs, etc.) Was this the case with your child? N / Y

Is/has your child been involved in any high impact or contact type sports (i.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.?) N / Y List: \_\_\_\_\_

Has Your Child Ever Been Involved in a Car Accident? N / Y, List: \_\_\_\_\_

Has Your Child Been Seen on an Emergency Basis? N / Y, List: \_\_\_\_\_

Other Traumas Not Described Above? N / Y, List: \_\_\_\_\_

Prior Surgery N / Y, List: \_\_\_\_\_

Menarche: N / Y, Age \_\_\_\_\_

Childhood Diseases:

Chicken Pox N / Y, Age \_\_\_\_\_ Mumps N / Y, Age \_\_\_\_\_

Rubella N / Y, Age \_\_\_\_\_ Whooping Cough N / Y, Age \_\_\_\_\_

Rubeola N / Y, Age \_\_\_\_\_ Other N / Y, Age \_\_\_\_\_

Sleeping Habits: Any problems with bed-time? \_\_\_\_\_

In what position does your child sleep? \_\_\_\_\_

Hours total that your child sleeps? \_\_\_\_\_

Do they wake in the night? N / Y How many times? \_\_\_\_\_

Does this child, or any other child of yours have problems with bedwetting? N / Y

For Mothers: Are you taking Birth Control? N / Y Are you pregnant? N / Y

WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS.  
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

Authorization for Care of Minor

I hereby authorize this office and its Doctors 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. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility and duty to inform this office of any future changes in medical status including any accidents, injuries, falls, etc.

For insurance: I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I acknowledge that the filing of my insurance is done as a courtesy by the provider and does not release me of my obligation to pay for services. I also authorize the provider to release information required to process insurance claims.

Name of Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Signed: \_\_\_\_\_ Witnessed: \_\_\_\_\_ Date: \_\_\_\_\_